UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA Respondent, v JOSEPH GUAGLIARDO Defendant/Movant.	Case Number: 1:20-CR00023-01 (DLC)

MOTION FOR COMPASSIONATE RELEASE/MODIFICATION OF SENTENCE PURSUANT TO 18 U.S.C. §3582(c)(1)(A)(i) AND MEMORANDUM IN SUPPORT THEREOF

Joseph Guagliardo, Movant pro se, hereby respectfully moves this Court for Compassionate Release/Modification of Sentence pursuant to 18 U.S.C. §3582(c)(1)(A)(i) for reason of the extraordinary and compelling circumstances as set forth herein.

STATEMENT OF JURISDICTION

This Court has jurisdiction to hear the instant motion pursuant to 18 U.S.C. §3582(c)(1)(A)(i), as amended by the First Step Act (the "FSA") stating in part:

> "the court upon motion of the defendant after the defendant has exhausted all administrative rights to appeal the failure of the Bureau of Prisons to bring a motion on the defendant's behalf or the lapse of 30 days from the receipt of such a request... whichever is earlier."
>
> (Id.) (emphasis added)

As evinced by the 'Request for Compassionate Release' dated and submitted to the Warden at F.C.I. Fort Dix on October 27, 2020, (Exhibit 'A') and the lapse of 30 days prior to the filing date of

the instant motion, jurisdiction of the Court has been duly established. No prior application for the relief sought herein has been made.

BACKGROUND

The Movant is currently incarcerated at F.C.I. Fort Dix minimum security camp pursuant to a conviction for embezzlement and a sentence of 27 months incarceration to be followed by 3 years of supervised release. The current projected release date without application of FSA programming/productive activity credits or Elderly Offender Home Confinement Transfer Program is December 2, 2022.

GROUNDS FOR RELIEF

I suffer from the following medical conditions, nearly all of which are recognized as CoVid-19 elevated risk factors:

1.) Prostate Cancer
2.) Asthma
3.) Rhinosinusitis
4.) Gastroesophageal Reflux Disease (GERD)
5.) Sleep Apnea
6.) Complex Post-Traumatic Stress Disorder (CPTSD)
7.) Adult Attention Deficit Disorder
8.) Primary Osteoarthritis (Back, Feet, Shoulder)
9.) Hypercholesterolemia
10.) Hypertension
11.) Coronary Artery Disease
12.) Morbid Obesity

I am also 63 years of age which the CDC recognizes as a stand-alone risk factor for CoVid-19. Detailed information and documentation

of my health conditions is annexed hereto at Exhibit 'A' and it is respectfully requested that it be deemed incorporated here as if fully set forth hereat.

THE ABOVE-CITED HEALTH CONDITIONS AND CO-VID RISK FACTORS HAVE BEEN EXACERBATED BY B.O.P. MALFEASANCE AND DELIBERATE DISREGARD

At my surrender interview, all my prescription medications were taken from me and have not been returned. As shown in Exhibit 'A', these medications were prescribed to treat my prostate cancer, respiratory conditions, and mental and physical stress problems.

Also at my surrender interview, I was forced to surrender my prescription footwear, and did not receive any replacements. Since September 4, 2020 I have been forced to wear "shower shoes" that do not fit, do not protect me from the cold, and aggravate my chronic arthritis and lower back pain.

At the conclusion of my surrender interview, I was directed to a so-called "quarantine unit" located in an abandoned laundry room. The B.O.P.'s characterization of this facility as a "quarantine unit," as claimed in numerous court filings here and in other jurisdictions, is a blatant misrepresentation for the following reasons:

1.) The "quarantine unit" was initially occupied by two inmates, but over the course of 20 days the population was increased to 10 prisoners.
2.) Due to the small size of the laundry room, occupied bunks were located less than three (3) feet apart.
3.) There was only one shared shower.
4.) There was only one shared toilet.
5.) No drinking water was available other than from a shared ice bucket.

6.) There was no social distancing, no wearing of masks, and otherwise no compliance with protocols of the CDC and State of New Jersey.

7.) We were confined to the laundry room 24 hours per day, with no fresh air or sunshine— the lack of which is a well-known immune system suppressor.

8.) When new inmates were assigned there, the "quarantine period" was extended indefinitely.

9.) Fort Dix staff left the institution daily, exposing them to CoVid-19, which they subsequently brought into the prison, inclusive of quarantine units.

10.) An inmate in the quarantine unit tested positive for CoVid and was removed from the building. The remaining inmates were not tested and were required to gather the infected inmate's belongings, thereby exposing them to risk of infection.

11.) No cleaning or sanitizing of the building occurred, before nor after the positive CoVid case.

12.) During the entire time of my quarantine, I was denied all my medications and medically prescribed footwear. I was forced to wear shower shoes the entire time.

13.) On October 29, 2020, I was transferred to Fort Dix Camp, where conditions are overall no better than they were in the quarantine unit. Specifically:

a.) We sleep less than 3 feet apart.

b.) No masks are worn regularly.

c.) Hand sanitizer is rarely available or used.

d.) The facility is not cleaned or sanitized

14.) I have furthermore still not received the prescribed and necessary footwear. (I am still wearing shower shoes) I have also been denied the following prescribed medications:

a.) Hydrocordone 10/325 PO TID

b.) Metocalhamol 500mg.

c.) Dextroamp- Amphetamine
d.) Montelukast 10mg
e.) Prescribed shoes for arthritis
f.) Replacement parts for C-Pap machine

As has been widely reported in the media and verifiable on the B.O.P's website (www.bop.gov) the number of active Co-Vid cases at Fort Dix has been over two-hundred (200) for several weeks, plus over a dozen infected staff members.

Several additional factors support the granting of this motion. My incarceration has deprived my wife of her primary caregiver at a time when she is suffering from breast cancer. Being that I self-surrendered to incarceration, there is a greater likelihood that I will comply with all conditions of home confinement and supervised release. Additionally, the non-violent nature of the crime of conviction— my first offense, coupled with the absence of any history of alcohol or drug abuse, speaks well of the prospects for the Court never regretting a decision to grant the motion.

It should also be noted that I have been found to be permanently disabled by both the Social Security Administration and the New York City Pension Fund. As such, I will be able to support myself at home and my release thereto will not place any burden upon society. I will be living with my wife at 120 Bevy Court, Brooklyn, NY 11231, with sufficient space to self-quarantine if needed.

Numerous courts have granted similar §3582 motions brought by Fort Dix inmates in recent months, in part because of the inability of the institution to protect vulnerable inmates. See e.g. U.S. v Maher 2020 US Dist Lexis 168001 September 15, 2020; U.S. v Morales 2020 US Dist Lexis 164016 September 8, 2020.

CONCLUSION

Whereas it has been herein shown that the Movant is particularly vulnerable to CoVid-19 and its complications, and that the virus is rampant at Fort Dix where the B.O.P. has been negligent and continues to be unable or unwilling to take the prudent steps to protect those in its custody; And whereas it has been shown that the B.O.P. has denied the Movant prescribed medication which is critically needed to maintain his health and well-being, the Court should grant the Motion and modify his sentence to a term of home confinement to be followed by supervised release.

Respectfully submitted,

Dated: November 24, 2020

Joseph Guagliardo
Defendant/Movant pro se

Joseph Guagliardo #87290-054
F.C.I. P.O. Box 2000
Joint Base MDL, NJ 08640

AFFIRMATION

I, the undersigned Joseph Guagliardo, Movant pro se, hereby affirm under penalty of perjury that the foregoing Motion and Memorandum in Support thereof is true to the best of my knowledge and belief.

Dated: November 24, 2020

Joseph Guagliardo

CERTIFICATE OF SERVICE

I, the undersigned Joseph Guagliardo, hereby affirm under penalty of perjury that a true copy of the Motion and Memorandum in Support filed pursuant to §3582 was deposited in the outgoing inmate mail at Fort Dix, New Jersey on November 24, 2020. It was addressed to United States Attorney, One St. Andrews Plaza, New York, NY 10007, and had sufficient First Class Postage affixed thereto.

Dated: November 24, 2020

Joseph Guagliardo

Request for Compassionate Release

Joseph A. Guagliardo

87290-054

Submitted 10/27/20

EX

I, Joseph Guagliardo (Reg.#87290-045) hereby submit this (i) Request for Compassionate Release pursuant to applicable provisions of law including, but not limited to, The Cares Act of 2020 and (ii) request for reduction in sentence/home confinement under applicable law.

I am applying for the requested relief due to my elevated risk of contracting COVID-19 as detailed herein. Additionally, my spouse, Dr. Hilary Baldwin-Guagliardo, lives alone and requires knee surgery that will render her immobile. Furthermore, she is a breast cancer patient and must be assisted with chores and driven to medical appointments. I am her primary care provider. Lastly, I am also the primary care provider to my elderly aunt, Judy Gagliardo and her son, Evan Aranoff who suffers from severe non-verbal autism. My aunt lives alone and suffers from numerous medical problems including end-stage kidney failure.

Since my incarceration on 9.4.20, I have been confined to a "quarantine" room with nine (9) other inmates. One of those inmates tested positive for COVID-19 and was removed from the "quarantine" room. The "quarantine" room has no safety protocols being utilized; we cannot observe social distancing and no one wears masks or other PPE. We eat together and all beds are less than six (6) feet apart, the CDC-mandated distance. My "quarantine" of 14 days has been extended 5 times thus far, with the admission of new inmates and the recent removal of the inmate who contracted COVID-19. I have not been given a date for the end of "quarantine". Based upon prior experience, it could be extended indefinitely, especially considering that the inmate contracted COVID-19 while in the "quarantine". As of the date of this letter, I have been in "quarantine" for over 60 days – a sentence that was never imposed upon me.

Due to the medical conditions detailed below, I am concerned with both contracting COVID-19 and experiencing severe, perhaps deadly consequences. Furthermore, as set forth above, I am needed to care for my wife, my elderly aunt and my autistic cousin.

I respectfully submit that I meet the criteria for compassionate release, reduction in sentence and/or home confinement under applicable law.

Denial of Medications, evaluations and treatments

I was assured by Judge Cote (SDNY), my sentencing judge, that I would receive all of my prescribed medications and have access to treatments and recommended protocols when I was sentenced to the prison camp at Fort Dix. So far that has been far from the case.

As set forth herein, I have severe medical and psychological diseases and conditions that require regular use of prescribed medications. The medications that I have been denied are slowly dimming my hope of successfully completing my sentence without long term and permanent damage to my health, well-being and mental state.

The sentence that I am currently serving in a laundry room "quarantine" is without definite end and is not the sentence that was imposed upon me. I have been denied access to medication, the law library, outdoor exercise and have been forced to live with a COVID-19 diagnosed inmate without any social distancing, use of PPE or even the semblance of adherence to CDC - mandated protocol. Additionally, I share my laundry room with 8 other inmates who share my concerns.

As of this date, I have been denied of the following medications, CPAP replacement parts, evaluations and treatments prescribed/recommended by specialists in their respective fields:

Medications: Advair HFA 115/31, Loratidine 20 mg, Ritalin, Hydrocodone-acetominophen 10/325mg

Evaluations: 1) Results of prostate MRI performed prior to incarceration which is apparently significant (as evidenced by a certified letter sent to my home by the ordering physician), 2) Repeat prostate biopsy to determine possible spread of my prostate cancer, 3) MRI of my left bicep to determine if a recent-onset tumor is cancerous, 4) Evaluation of a recent spike in my PSA

CPAP replacement parts: 1) Filters (Phillips Respironics Disposable Untra fine filter Part # 1122447), 2) Gel Nasal Pillow (Phillips Respironics Part # 1125037, 3) Heated breathing tube (Phillips Respironics Part # ROC2300)

Treatments: 1) Physical therapy/surgery for frozen left shoulder, 2) Biopsy/removal of painful left bicep tumor, 3) Physical therapy and prescribed exercise to combat obesity, coronary artery disease and osteoarthritis, 4) Prescribed shoes (assigned boots are too big, commissary fitted me with the wrong size sneakers). I have been forced to wear only shower shoes that have exacerbated my back pain and arthritis.

Medical Conditions

As a predicate matter, it must be noted that I suffer from the following medical and psychological conditions, all of which have been identified as rendering anyone suffering from such conditions as being uniquely susceptible to contracting and perishing from COVID-19.

PROSTATE CANCER

As a result of my volunteer work at and around the World Trade Center site following the terrorist attacks of 9/11/01, I am suffering from prostate cancer. Attached hereto as Exhibit "A" and made a part hereof is the World Trade Center Health Program diagnosis that details my prostate cancer condition. Prior to my voluntary surrender at Fort Dix, I was being actively monitored by Dr. Jeffrey T. Schiff at Winthrop Hospital (NYU-Langone Health Center). On 8/31/20, five days prior to my surrender date, I was given a six month blood test and quarterly

medical test. I received my results on the day of my surrender, 9.4.20. The test results indicated that my PSA level had spiked up 2.0 points in only 6 months (according to Dr. Robert Kelter, a new primary care provider provided to me by the NYU Langone Health Care System). My medical records attesting to the spike in my PSA are annexed hereto as Exhibit "B" and made a part hereof.

Since my incarceration, Dr. Schiff has sent a letter to my home residence in Brooklyn N.Y., advising me to call the office for an immediate consultation regarding my MRI and to schedule an additional examination. This would likely result in a biopsy to determine my Gleason Score, a cancer severity indicator. This would determine the possibility of spread of my prostate cancer as detailed in the World Trade Center Health Program diagnosis, attached hereto as Exhibit "A" and made a part hereof.

I also discussed an alarming, rapidly enlarging lump in my left arm with Dr. Kelter who suspected the possibility of cancer metastasis and recommended an MRI to confirm the diagnosis in addition to a necessary consultation with Dr. Schiff. This remains unevaluated.

I am particularly concerned about the lack of attention to my outstanding MRI and 2-point PSA increase as rapid rise in PSA (PSA velocity) has been associated with poor disease outcome (Vickers and Brewster, *PSA velocity and doubling time in diagnosis and prognosis of prostate cancer*. Br J Med Surg Oncol 2012 5(4):162-168). Additionally prostate cancer has been reported as an aggravating COVID-19 condition detailed in applicable CDC guidelines as well as numerous publications including the large study: *Clinical characteristics and risk factors associated with COVID-19 disease severity in patients with cancer in Wuhan China: A multicenter retrospective cohort study*. Lancet Oncol 2020;21(7):873-903.

Lastly, my prostate cancer causes me to urinate frequently, often without warning. I have occasionally not made it to the urinal in time. There are also times that I urinate and moments later much urinate again without warning.

ASTHMA

As indicated in the World Trade Center Health Program diagnosis, attached hereto as Exhibit "A" and made a part hereof, I have been diagnosed with asthma. Asthma is an underlying risk factor for COVID-19 acquisition as well as a condition associated with poor disease outcome. This is identified in http://cdc.gov>coronavirus>22019-mcov>need-extra-precautions/index.html (accessed 10.20.20) and Zheng A et al, *Risk factors of infection and normal COVID-19 cases: A systematic literature review and meta-analysis.* Infect 2020;81(2):e15-e25.

I have been prescribed Albuterol sulfate 90 mcg, Montelukast 10 mg and Advair HFA for my severe asthma. As of the date of this letter, I have been denied access to Advair HFA and Montelukast despite specifically prescribed for same by my doctors. The denial is due to the policy of Fort Dix and places me in immediate and present danger. It must be noted that upon

admission to Fort Dix, my 60-day supply of Montelukast was confiscated and has never been returned.

My severe asthmatic condition causes me to wake throughout the night. When I wake, I suffer extreme sneezing and coughing fits which exacerbate my severe back pain and arthritic pain. Furthermore, my involuntary sneezing and coughing alarms my fellow inmates by making them concerned that I am infected with COVID-19. If I have become infected due to exposure to my fellow infected inmate here in "quarantine", I am spraying fomites on my inmates who are in close proximity to me without PPE.

On 10.10.20, I suffered a severe asthmatic attack that required medical intervention by the Fort Dix medical staff. This is likely due to the absence of my preventative dose of Montelukast. I was given a steroid injection and placed on a course of prednisone. Although I feel better, the use of immunosuppressive medications such as corticosteroids are an additional risk factor for severe COVID-19 infection (http://cdc.gov>coronavirus>22019-mcov>need-extra-precautions/index.html (accessed 10.20.20)).

RHINOSINUSITIS

As indicated in the World Trade Center Health Program diagnosis annexed hereto as Exhibit "A" and made a part hereof, I have been diagnosed with the upper respiratory disease chronic rhinosinusitis. Chronic rhinosinusistis has been identified as a risk factor for COVID-19 acquisition and severe disease (http://cdc.gov>coronavirus>22019-mcov>need-extra-precautions/index.html (accessed 10.20.20)).

This condition causes the sinuses to close due to inflammation and severely impacts my breathing, causes severe headaches, eye tearing and congested, labored breathing. This condition wakes me at night causing interrupted sleep and back pain due to jolting and gasping for air.

GASTROESOPHAGEAL REFLUX DISEASE (GERD)

As indicated in the World Trade Center Health Program diagnosis annexed hereto as Exhibit "A" and made a part hereof, I have been diagnosed with GERD. My personal gastroenterologist, Dr. Paul Cohen independently verified the diagnosis. GERD causes pain and and exacerbates my respiratory conditions. It further interrupts my sleep and aggravates my back injuries and arthritic condition. I have been prescribed famotidine tablets by Dr. Cohen to treat GERD and acid reflux. I have also been recommended GasEx, an OTC product. Although famotidine has been certified, I have been denied GasEx due to total lack of Commissary access and mail delivery policies of Fort Dix.

SLEEP APNEA

I have been diagnosed with severe obstructive sleep apnea and require a CPAP machine to breath at night. A sleep study report detailing this diagnosis and prescribed CPAP machine is annexed hereto as Exhibit "C" and made a part hereof.

Due to intermittent power failures (the CPAP has no battery backup system), the lack of distilled water, the lack of air filter equipment, the lack of appropriate head gear and replacement nasal pillow (a piece that fits between the hose and the headgear), the CPAP machine has not performed consistently or with the efficiency for which it was designed. The prescribed unit has been certified by the medical personnel at Fort Dix.

The dirt and dust from the "quarantine" area travels through the CPAP machine because there is no air filtration in the "quarantine" unit. This causes sinus aggravation and stuffiness that exacerbates my upper respiratory conditions, my sinus condition and further interrupts my sleep resulting in severe headache and back pain to my previously fractured and surgically repaired L4, L5, S1 and S2 vertebrae as well as aggravating my arthritic condition.

Sleep apnea is considered to be an independent risk factor for contracting COVID-19 and untoward outcomes (Cade B, et al, *Sleep apnea and COVID-19 mortality and hospitalization*. Am J Resp Crit Care Med 2020:September epub ahead of print).

COMPLEX POST TRAUMATIC STRESS DISORDER (CPTD)

I have been diagnosed with complex post traumatic stress disorder by Dr.Douchous of the World Trade Center Program. My CPTD is attributable to numerous traumatic events that occurred throughout my life and increased exponentially after the attacks on the World Trade Center where I lost many close friends while at the same time bringing my children into this world one month later.

I have been seeing Dr. Steven Wachsal, a psychologist, since 2008 for CPTD for severe anxiety and stress disorders. Prior to my incarceration, I commenced intensive therapy with the WTC Health Program. At my surrender at Fort Dix, the intake psychiatrist concurred with the CPTD diagnosis and indicated that I might be able to get assistance while incarcerated, perhaps even remotely. Upon admission in the "quarantine", I was informed that I would not be able to get any assistance from the psychiatric unit unless I fell into the policy that was being followed at Fort Dix. To date, I have not received any psychiatric assistance despite being assured of availability upon my intake.

I went from long term care with dedicated and trained medical personnel with two independent evaluations to receiving no assistance or treatment at all.

ADULT ATTENTION DEFICIT DISORDER

I have been diagnosed with adult attention deficit disorder by Dr. Vatsal Thakkar of NYU, a leading authority in the field and two psychiatrists specializing in the disorder, Andrew Slaby and Barry Holzer. After undergoing extensive testing, these three doctors independently

diagnosed my condition. A report detailing this diagnosis and prescribed medication is annexed hereto as Exhibit "D" and made a part hereof.

I have been prescribed Adderal in an effort to assist my concentration. Due to the policy at Fort Dix, I have been denied access to this medication. It should be noted that I brought a 30 day supply of Ritalin with me which was confiscated upon my admission to Fort Dix.

I have been denied access to the law library, which, combined with my ADD has compromised my ability to make a thorough application for the relief requested herein. Furthermore, I have been denied the resources of a formal inmate orientation to better acquaint myself with the process to make the application.

PRIMARY OSTEOARTHRITIS

As noted in the medical reports attached hereto as Exhibit "B" and made a part hereof, I have been diagnosed with primary osteoarthritis in several joints. This condition was caused by numerous injuries to my back, hands, shoulders, feel and knees.

The pain that I experience from doing something as simple as typing or writing can be excruciating and debilitating. This request has taken me several days to prepare and submit due to my inability to write after compiling the material.

As set forth later in this application, I have been receiving physical therapy to treat a heart condition and morbid obesity. This physical therapy is required to allow me to undergo Cyberknife, a preferred treatment for my prostate cancer. Because in "quarantine", we are denied all exercise, I have not been able to simulate even a fraction of the activity I received during physical therapy. By being denied all physical activity, I have exacerbated my osteoarthritic condition which has resulted in severe pain that further inhibits my sleep activity.

I have been prescribed hydrocodone acetaminophen 10/325 PO TID for daily use. This medication alleviated the pain associated with my arthritis and allowed me to undergo my required physical therapy. In accordance with Fort Dix Policy, I have been denied this medication and simple activities, like walking, are unbearable.

Furthermore, to alleviate by severe arthritic pain, I have previously received spinal injections of steroids and pain medications that were administered by Dr.Kenneth Chapman in Staten Island, N.Y.

All of my pain medication has been denied and has been replaced with aspirin and ibuprofen which is wholly inadequate in addition to being contraindicated considering my diagnosis of GERD. In fact, I was denied access to even the aspirin and ibuprofen for the first month that I spent in "quarantine".

HYPERCHOLESTEROLEMIA AND HYPERTENSION

I have been diagnosed with high blood pressure and high cholesterol intermittintly since 2004 by primary care physicians Dr. Eugene Mancuso and Dr. Robert Kelter at NYU-Langone.

I came to Fort Dix with a 30-day supply of Vytorin, my prescribed cholesterol medication. It was confiscated upon my admission and I was denied all cholesterol medication until 10/20/20 (46 days into "quarantine") when I was prescribed a generic medication that has been ineffective.

Due to Fort Dix policy, my initial prescription for high blood pressure medication has not been filled. As you can imagine, this is a very concerning situation. Hypertension is considered an independent risk factor for COVID-19 acquisition and severity (Hamer M, et al. *Lifestyle risk factors, inflammatory mechanisms and COVID-19 hospitalizations: A community-based cohort study of 387,109 adults in the UK.* Brain Behav Immunol 2020;87:184-187).

CORONARY ARTERY DISEASE

I have been diagnosed with severe (50%-75%) coronary artery calcification, scoring a 217.29 on the relevant test. The testing was performed 7.17.20 at NYU-Langone upon the recommendation of cardiologist Dr. Archiana Saxenia as noted in the medical reports attached hereto as Exhibit "B" and made a part hereof.

I have been prescribed ASA 81 mg, metoprolol 25 mg QD and mild daily exercise. Although I have received the medications thus far, I have been denied all physical activity in our laundry room "quarantine" since 9.4.20. Being totally dormant is in contradiction to the treatment and care that was prescribed to me prior to my surrender. Left untreated, my diagnosed coronary arterial calcification could become worse and lead to a severe cardiac condition.

Both cardiac disease and inactivity are considered independent risk factors for COVID-19 acquisition and severity (Hamer M, et al. *Lifestyle risk factors, inflammatory mechanisms and COVID-19 hospitalizations: A community-based cohort study of 387,109 adults in the UK.* Brain Behav Immunol 2020;87:184-187, (http://cdc.gov>coronavirus>22019-mcov>need-extra-precautions/index.html (accessed 10.20.20)).

MORBID OBESTIY

I was formally diagnosed with Class 3 severe morbid obesity in June, 2010, but was documented by Dr. Paul Cohen as early as 2010. This condition is considered an independent risk factor for COVID-19 acquisition and severity (*Hamer M, et al. Lifestyle risk factors inflammatory mechanisms and COVID-19 hospitalizations: A community based cohort study of 387,109 adults in the UK.* Brain Behav Immunol 2020; 8(18):184-187).

I continue to applaud the work of the civil servants taking care of me under these unprecedented times. I can't,however, help but see that I am falling through the cracks of the very system in which I still believe.

WTC Health Program
PO Box 7002
Rensselear, NY 12144

Appendix A

Joseph Gagliardo
120 Bevy Court
Brooklyn, New York 11231

Re: 911S24868

10/14/2020

Dear Joseph Gagliardo:

This letter is to inform you that after reviewing medical information provided by the Health and Hospitals Corporation (H+H), the World Trade Center (WTC) Health Program has certified the following health condition(s) as covered for treatment benefits:

Date of Certification	Condition Category on List of WTC-Related Health Conditions*	Certification Category or Injury
8/11/2020	Mental Health	Please Contact your WTC Physician for Specific Information

* As listed in the James Zadroga 9/11 Health and Compensation Act of 2010 and/or 42 C.F.R. § 88.15

Our records also indicate that you are currently certified for the following health condition(s) as covered for treatment benefits:

Date of Certification	Condition Category on List of WTC-Related Health Conditions*	Certification Category or Injury
10/25/2019	Asthma	Obstructive Airway Disease Please Contact your WTC Physician for Specific Information
10/25/2019	Cancer	Malignant Neoplasm Of Prostate
10/25/2019	Chronic Rhinosinusitis	Upper Respiratory Disease Please Contact your WTC Physician for Specific Information
10/25/2019	Gastroesophageal Reflux Disease (Gerd)	Gastroesophageal Reflux Disease Please Contact your WTC Physician for Specific Information

* As listed in the James Zadroga 9/11 Health and Compensation Act of 2010 and/or 42 C.F.R. § 88.15

In addition, the following health condition(s) medically associated with your WTC-related health condition(s) have also been certified as covered for treatment benefits:

Date of Certification	Condition Category on List of WTC-Related Health Conditions*	Medically Associated Condition
7/28/2020	Medically Associated to Chronic Rhinosinusitis	Obstructive sleep apnea

* As listed in the James Zadroga 9/11 Health and Compensation Act of 2010 and/or 42 C.F.R. § 88.15

The WTC Health Program will only provide payment for medically necessary treatment(s) authorized by your WTC Health Program physician for your certified health condition(s) by a WTC Health Program participating provider.

If you would like more information or believe that a health condition is missing, incorrect, or should be removed, please discuss this with the Health and Hospitals Corporation (H+H) at 212-562-1720. If the information in this letter is correct, no further action is necessary.

If you have any other questions, you may contact the WTC Health Program at 1-888-982-4748 Monday through Friday, 9 AM to 5 PM (Eastern Time Zone).

Sincerely,

John Howard, M.D.,
Administrator, World Trade Center Health Program
Copy to: Director, Clinical Center of Excellence

Appendix B

Joseph Gagliardo

Patient Health Summary, generated on Sep. 01, 2020

Patient Demographics - Male; born Jun. 24, 1957

Patient Address	Communication	Language	Race / Ethnicity	Marital Status
PO Box 310495 Brooklyn, NY 11231-0495	917-670-3336 (Mobile) 718-769-1106 (Home) josephg@efn.org	English (Preferred)	White / Unknown	Married

Note from NYU Langone Medical Center

This document contains information that was shared with Joseph Gagliardo. It may not contain the entire record from NYU Lang
Medical Center.

Allergies

No Known Allergies

Medications

HYDROcodone-acetaminophen (NORCO) 10-325 mg per tablet (Started 12/6/2018)
Take 1 tablet by mouth 3 (three) times daily.
ezetimibe/simvastatin (VYTORIN 10-10 ORAL)
Take by mouth daily.
diazePAM (VALIUM) 10 mg tablet (Started 10/31/2018)
Prn as per patient on 06/22/20
furosemide (LASIX) 80 mg tablet (Started 4/21/2018)
Take 80 mg by mouth daily.
methylphenidate HCl (RITALIN) 10 mg tablet (Started 6/14/2018)
Prn as per patient on 06/22/20
omeprazole (PRILOSEC) 40 mg capsule (Started 12/23/2018)
Take 40 mg by mouth daily.
phentermine (ADIPEX-P) 37.5 mg tablet (Started 12/6/2018)
Take 37.5 mg by mouth daily.
Miscellaneous Medical Supply Misc (Started 6/15/2020)
Custom made orthotics
(g57.92) neuropathy of left foot
(g57.91) neuropathy of right foot
(m21.6x9) cavus foot, acquired
(m19.071, m19.072) primary osteoarthritis of both feet
multivitamin with minerals tablet
Take 1 tablet by mouth daily.
albuterol sulfate 90 mcg/actuation HFA inhaler (Started 6/12/2020)
Inhale 90 puffs into the lungs daily.
aspirin (ECOTRIN) 81 mg EC tablet (Started 6/15/2020)
Take 1 tablet by mouth daily. enteric coated
methocarbamoL (ROBAXIN) 500 mg tablet (Started 6/14/2020)
Take 1 tablet by mouth once daily if needed
fluticasone propion-salmeterol (ADVAIR HFA) 115-21 mcg/actuation inhaler (Started 7/20/2020)
Inhale 2 puffs into the lungs 2 (two) times daily.
melatonin 10 mg Tab
Take 10 mg by mouth daily.
fluticasone propionate (FLONASE) 50 mcg/actuation nasal spray (Started 7/20/2020)
2 sprays by nasal route daily.
loratadine (CLARITIN) 10 mg tablet (Started 7/20/2020)
Take 10 mg by mouth daily.
metoprolol succinate (TOPROL XL) 25 mg XL tablet (Started 8/7/2020)
Take 1 tablet by mouth daily.
montelukast (SINGULAIR) 10 mg tablet (Started 8/3/2020)
Take 10 mg by mouth every evening.
ezetimibe-simvastatin (VYTORIN) 10-20 mg per tablet (Started 8/3/2020)
Take 1 tablet by mouth daily.

Active Problems

Class 3 severe obesity due to excess calories without serious comorbidity in adult (Noted 6/22/2020)
Frozen shoulder (Noted 6/22/2020)
Malignant neoplasm of prostate (Noted 12/27/2018)
Primary osteoarthritis involving multiple joints (Noted 6/22/2020)
Subacromial bursitis of left shoulder joint (Noted 6/22/2020)

Procedures

ECHOCARDIOGRAM TRANSTHORACIC, COMPLETE (Performed 7/17/2020)
Performed for Dyspnea on exertion, Abnormal EKG
HOLTER MONITOR (Performed 7/7/2020)
Performed for Abnormal EKG

Results

T3 UPTAKE AND FTI (T3, TOTAL) - Final result (08/31/2020 10:29 AM EDT)

Component	Value	Ref Range	Performed At	Pathologist Sign
T3 TOTAL	139	80 - 200 ng/dL	SUNRISE	

Specimen
blood - Peripheral vein

Performing Organization	Address	City/State/Zipcode	Phone Number
SUNRISE			

URINALYSIS WITH REFLEX TO MICROSCOPY (URINALYSIS (NO CULTURE) WITH REFLEX TO MICROSCOPY) - Final re
(08/31/2020 10:29 AM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signatur
PH	5.0	5.0 - 8.0	SUNRISE	
SPECIFIC GRAVITY, URINE	1.018	1.005 - 1.030	SUNRISE	
APPEARANCE, URINE	Cloudy	CLEAR	SUNRISE	
COLOR, URINE	Amber	YELLOW	SUNRISE	
PROTEIN, URINE	NEGATIVE	NEGATIVE	SUNRISE	
GLUCOSE,URINE	NEGATIVE	NEGATIVE	SUNRISE	
KETONE	NEGATIVE	NEGATIVE	SUNRISE	
BILIRUBIN, URINE	NEGATIVE	NEGATIVE	SUNRISE	
BLOOD	NEGATIVE	NEGATIVE	SUNRISE	
LEUKOCYTE ESTERASE, URINE	NEGATIVE	NEGATIVE	SUNRISE	
NITRITE, URINE	NEGATIVE	NEGATIVE	SUNRISE	
UROBILINOGEN	<2	<2 mg/dl	SUNRISE	
WBC,URINE	NONE	0 - 5 HPF	SUNRISE	
RBC,URINE	0-2	0 - 2 HPF	SUNRISE	
EPITHELIAL CELLS	FEW	NONE	SUNRISE	
BACTERIA	<FEW	<FEW	SUNRISE	
MUCOUS	NONE	<=FEW	SUNRISE	
CALCIUM OXALATE CRYSTALS	FEW	NONE	SUNRISE	
HYALINE CASTS	0-2	<3 LPF	SUNRISE	

Specimen
Urine - Urine, voided

Performing Organization	Address	City/State/Zipcode	Phone Number
SUNRISE			

CBC WITH DIFFERENTIAL - Edited Result - FINAL (08/31/2020 10:29 AM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signa
WHITE BLOOD CELL COUNT	5.9	3.6 - 11.0 THDS/CMM	SUNRISE	
RED BLOOD CELL COUNT	5.28	4.40 - 6.10 MILL/CMM	SUNRISE	
HEMOGLOBIN	14.9	13.0 - 18.0 G/DL	SUNRISE	
HEMATOCRIT	43.8	39 - 52 %	SUNRISE	
MEAN CORPUSCULAR VOLUME	83	75 - 100 fL	SUNRISE	
MEAN CORPUSCULAR HEMOGLOBIN	28.2	26.0 - 32.0 pg	SUNRISE	
MEAN CORPUSCULAR	34.0	32.0 - 35.0 g/dl	SUNRISE	

CONC			
RED CELL DISTRIBUTION WIDTH	13.3	11.2 - 14.8 %	SUNRISE
PLATELET COUNT	175	140 - 440 THOUS/CMM	SUNRISE
POLYS	52.2	45 - 75 %	SUNRISE
LYMPHOCYTES %	33.3	20 - 45 %	SUNRISE
MONOCYTES %	10.1	0 - 13 %	SUNRISE
EOSINOPHILS %	3.0	0 - 5 %	SUNRISE
BASOPHILS %	1.2	0 - 2 %	SUNRISE
IMMATURE GRANULOCYTES	0.2	0 - 2 %	SUNRISE
NEUTROPHILS ABSOLUTE	3.10	1.9 - 8.0 K/uL	SUNRISE
ABSOLUTE LYMPHS	1.98	0.9 - 5.2 K/uL	SUNRISE
MONOCYTES ABSOLUTE	0.60	0.1 - 1.0 K/uL	SUNRISE
EOSINOPHILS, ABSOLUTE	0.18	0.0 - 0.80 K/uL	SUNRISE
BASOPHILS ABSOLUTE	0.07	0.0 - 0.2 K/uL	SUNRISE
ABSOLUTE IMMATURE GRANULOCYTES	0.01	0.00 - 0.06 K/uL	SUNRISE

Specimen

blood - Peripheral vein

Performing Organization	Address	City/State/Zipcode	Phone Number
SUNRISE			

TSH (THYROID STIMULATING HORMONE) - Final result (08/31/2020 10:29 AM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signatu
THYROID STIMULATING HORMONE	1.49	0.270 - 4.200 uIU/mL	SUNRISE	

Specimen

Performing Organization	Address	City/State/Zipcode	Phone Number
SUNRISE			

T4 FREE (T4, FREE, NON-DIALYSIS) - Final result (08/31/2020 10:29 AM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signatu
T4, FREE, DIRECT	1.51	0.80 - 1.90 ng/dL	SUNRISE	

Specimen

Performing Organization	Address	City/State/Zipcode	Phone Number
SUNRISE			

Component	Value	Ref Range	Performed At	Pathologist Signature
PSA TOTAL	8.580	0 - 4.00 ng/mL	SUNRISE	

Comment:
PSA levels should not be interpreted as absolute evidence of disease, however it is widely accepted as an adjunctive test in the management of prostate cancer patients. Values obtained with different assay methods or kits can not be used interchangeably.

A detectable PSA following radical prostatectomy is associated with eventual clinical disease recurrence in some, but not all patients. It may also be due to the presence of benign glands. The AUA defines biochemical recurrence as an initial PSA value >=0.2 ng/ml followed by a subsequent confirmatory PSA value >=0.2 ng/ml.

Specimen
blood - Peripheral vein

Performing Organization	Address	City/State/Zipcode	Phone Number
SUNRISE			

LIPID PANEL WITH LDL/HDL RATIO - Edited Result - FINAL (08/31/2020 10:29 AM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signat
CHOLESTEROL, TOTAL	139	100 - 199 mg/dL	SUNRISE	
HDL CHOLESTEROL	38	>=40 mg/dL	SUNRISE	
LDL CHOL,CALCULATED	71	<130 mg/dL	SUNRISE	

Comment:
ADULT LDL CHOLESTEROL CLASSIFICATION

<100mg/dL_____Optimal

100-129_____Near/Above Optimal

130-159mg/dL_____Borderline High

>160mg/dL_____High Risk

Desirable range <100 mg/dL

diabetes and
<70 mg/dL for diabetic
patients with known heart
disease.
Direct LDL is recommended for
patients with triglycerides
>400.

VLDL CHOLESTEROL, TOTAL DIRECT	30	<30 mg/dL	SUNRISE
TRIGLYCERIDES	152	20 - 149 mg/dL	SUNRISE
CHOLESTEROL/HDL RATIO	3.7	2.0 - 4.5	SUNRISE

Specimen

Performing Organization	Address	City/State/Zipcode	Phone Number
SUNRISE			

COMPREHENSIVE METABOLIC PANEL - Edited Result - FINAL (08/31/2020 10:29 AM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signatur
GLUCOSE	113	70 - 100 mg/dL	SUNRISE	
BLOOD UREA NITROGEN	16	8 - 23 mg/dL	SUNRISE	
SODIUM	141	135 - 148 mmol/L	SUNRISE	
CREATININE	1.28	0.40 - 1.40 mg/dL	SUNRISE	
GFR CALCULATION(CKD-EPI)	59	>59 ml/min/1.73m2	SUNRISE	
GFR IN AFRICAN AMERICAN(CKD-EPI)	69	>59	SUNRISE	
POTASSIUM	4.3	3.5 - 5.4 mmol/L	SUNRISE	
CHLORIDE	102	96 - 107 mmol/L	SUNRISE	
CARBON DIOXIDE	26	18 - 32 mmol/L	SUNRISE	
CALCIUM	9.9	8.6 - 10.5 mg/dL	SUNRISE	
PROTEIN, TOTAL	6.9	6.0 - 8.3 g/dL	SUNRISE	
ALBUMIN	4.6	3.5 - 5.2 g/dL	SUNRISE	
GLOBULIN	2.3	1.8 - 3.8 g/dL	SUNRISE	
A/G RATIO	2.0	1.0 - 2.5 RATIO	SUNRISE	
ALKALINE PHOSPHATASE	76	39 - 118 U/L	SUNRISE	
AST	31	9 - 50 U/L	SUNRISE	
ALT	29	5 - 50 U/L	SUNRISE	
BILIRUBIN TOTAL	0.6	<1.3 mg/dL	SUNRISE	

Specimen
blood - Peripheral vein

Performing Organization	Address	City/State/Zipcode	Phone Number
SUNRISE			

CT CORO ANGIO W/C & CT CHEST (CT ANGIO CORONARY WITH IV CONTRAST AND CT CHEST WITHOUT IVC) - result (08/06/2020 10:03 AM EDT)

Specimen

Performed At
NYU RADIOLOGY SWF

Impressions

IMPRESSION:

-THE AGATSTON CORONARY CALCIUM SCORE IS 217.29. THIS IS IN THE 50th-75th PERCENTILE FOR THE PATIENT'S AGE AND GENDER.

-CONTRAST ENHANCED CORONARY CT ANGIOGRAPHY DEMONSTRATES MULTIFOCAL CALCIFIED PLAQUE IN THE PROXIMAL AND MID LAD AND IN THE DISTAL CIRCUMFLEX RESULTING IN MILD (20-30%) STENOSIS. A FEW FOCI OF ECCENTRIC CALCIFIED PLAQUE ARE SEEN IN THE MID RCA RESULTING IN MINIMAL (LESS THAN 20%) STENOSIS. THIS IS A RIGHT DOMINANT SYSTEM.

-AORTIC VALVE CALCIFICATION.

(Grading of coronary artery stenosis is based on minimal: less than 20%, mild: 20-30%; mild-moderate: 30-50%; moderate: 50%; moderate-severe: 50-75%; or severe >75%)

Performed At
NYU RADIOLOGY SW

Narrative

CORONARY ARTERY CT ANGIOGRAM AND CORONARY CALCIUM SCORING

Reason for exam: Chest pain. Abnormal stress test. Hypercholesterolemia.

Comparison: No prior studies available.

TECHNIQUE: Coronary CT angiography was performed on a Siemens 128-slice multidetector CT scanner. A coronary calcium score was performed utilizing ECG gating. Contrast enhanced coronary CTA was then performed after the administration of intravenous contrast. In order to provide better visualization of the anatomy, advanced off-line 3-D post processing techniques, including maximal intensity projections and volume rendering, were performed on an independent workstation under concurrent supervision. Multiplanar 3D rendered images were created from the source images. This confirms the presence of the described findings.

Total contrast administered: 100 cc Isovue 370
Beta Blocker administered: 50 mg Lopressor (oral).
Nitroglycerin administered: 0.4mg Sublingual Nitroglycerin.

FINDINGS:

CORONARY CALCIUM SCORE: The Agatston coronary calcium score is 217.29. This is in the 50th-75th percentile for the patient's age and gender.

CONTRAST ENHANCED CORONARY CT ANGIOGRAPHY:

Left Main Coronary Artery: No soft plaque or stenosis is identified.

Left Anterior Descending (LAD): Multifocal calcified plaque is seen in the proximal and mid LAD resulting in mild (20%) stenosis. 2 large caliber diagonal branches are identified.

Circumflex Artery: 2 short segments of eccentric calcified plaque are identified in the distal circumflex resulting in mild (20-30%) stenosis. 3 small caliber obtuse marginal branches are noted.

Right Coronary Artery: A few foci of eccentric calcified plaque are seen at the junction of the proximal and mid RCA and in the mid RCA resulting in minimal (less than 20%) stenosis.

Dominance: This is a right dominant system.

Left Ventricular Ejection Fraction: 69%. Ventricular end diastolic volume: 192 mL. Ventricular end systolic volume: 59 mL. Wall motion is within normal limits.

Cardiac Chambers & Morphology: The cardiac chambers and morphology are grossly normal. A trileaflet aortic valve is seen. Focal dense aortic valve calcification is identified. Small pericardial fluid is identified.

ADDITIONAL FINDINGS: No suspicious pulmonary nodules are seen in the visualized portions of the lung parenchyma. There appears to be a lap band in place. Mild distention of the esophagus is noted with mild diffuse circumferential wall thickening.

Electronic Signature: I personally reviewed the images and agree with this report.
Final Report: Dictated by and Signed by Attending George Visvikis MD 8/6/2020 12:43 PM

Procedure Note

Interface, Rad In - 08/06/2020 12:45 PM EDT

CORONARY ARTERY CT ANGIOGRAM AND CORONARY CALCIUM SCORING

Reason for exam: Chest pain. Abnormal stress test. Hypercholesterolemia.

Comparison: No prior studies available.

TECHNIQUE: Coronary CT angiography was performed on a Siemens 128-slice multidetector CT scanner. A coronary calcium sc
was performed utilizing ECG gating. Contrast enhanced coronary CTA was then performed after the administration of intraveno
contrast. In order to provide better visualization of the anatomy, advanced off-line 3-D post processing techniques, including
maximal intensity projections and volume rendering, were performed on an independent workstation under concurrent supervis
Multiplanar 3D rendered images were created from the source images. This confirms the presence of the described findings.

Total contrast administered: 100 cc Isovue 370
Beta Blocker administered: 50 mg Lopressor (oral).
Nitroglycerin administered: 0.4mg Sublingual Nitroglycerin.

FINDINGS:

CORONARY CALCIUM SCORE: The Agatston coronary calcium score is 217.29. This is in the 50th-75th percentile for the patient'
and gender.

CONTRAST ENHANCED CORONARY CT ANGIOGRAPHY:

Left Main Coronary Artery: No soft plaque or stenosis is identified.

Left Anterior Descending (LAD): Multifocal calcified plaque is seen in the proximal and mid LAD resulting in mild (20%) stenosis
large caliber diagonal branches are identified.

Circumflex Artery: 2 short segments of eccentric calcified plaque are identified in the distal circumflex resulting in mild (20-30%
stenosis. 3 small caliber obtuse marginal branches are noted.

Right Coronary Artery: A few foci of eccentric calcified plaque are seen at the junction of the proximal and mid RCA and in the
RCA resulting in minimal (less than 20%) stenosis.

Dominance: This is a right dominant system.

Left Ventricular Ejection Fraction: 69%. Ventricular end diastolic volume: 192 mL. Ventricular end systolic volume: 59 mL. Wall m
is within normal limits.

Cardiac Chambers & Morphology: The cardiac chambers and morphology are grossly normal. A trileaflet aortic valve is seen
dense aortic valve calcification is identified. Small pericardial fluid is identified.

ADDITIONAL FINDINGS: No suspicious pulmonary nodules are seen in the visualized portions of the lung parenchyma. There
appears to be a lap band in place. Mild distention of the esophagus is noted with mild diffuse circumferential wall thickening.
Multilevel degenerative changes are seen in the lower thoracic spine.

Electronic Signature: I personally reviewed the images and agree with this report. Final Report: Dictated by and Signed by Att
George Visvikis MD 8/6/2020 12:43 PM

IMPRESSION:

-THE AGATSTON CORONARY CALCIUM SCORE IS 217.29. THIS IS IN THE 50th-75th PERCENTILE FOR THE PATIENT'S AGE AND
GENDER.

-CONTRAST ENHANCED CORONARY CT ANGIOGRAPHY DEMONSTRATES MULTIFOCAL CALCIFIED PLAQUE IN THE PROXIMA
MID LAD AND IN THE DISTAL CIRCUMFLEX RESULTING IN MILD (20-30%) STENOSIS. A FEW FOCI OF ECCENTRIC CALCIFIED P

ARE SEEN IN THE MID RCA RESULTING IN MINIMAL [illegible]

-AORTIC VALVE CALCIFICATION.

(Grading of coronary artery stenosis is based on minimal: less than 20%, mild: 20-30%; mild-moderate: 30-50%; moderate: 50% moderate-severe: 50-75%; or severe >75%)

Performing Organization	Address	City/State/Zipcode	Phone Number
NYU RADIOLOGY SWF			

US LOWER EXTREMITY ARTERIAL DOPPLER - Final result (08/03/2020 9:43 AM EDT)

Specimen

Narrative

Performed At
NYU SYNGO DYNAMIC

NYU Langone Ambulatory Care Bay Ridge
6740 Fourth Ave, 2nd Floor, Brooklyn, NY 11220
Tel: 929.455.2740 Fax: 929.455.2750

Lower Arterial Duplex Report

Pt. Name:	JOSEPH GAGLIARDO	Study Date:	8/3/2020
Pt. ID:	11002267	Accession #:	20301479
DOB:	6/24/1957	EPIC Code:	IMG16414
Age:	63	Height:	75 in(191 cm)
Gender:	M	Weight:	322 lb (146 kg)
Location:		BSA:	2.69 m²

Referring Physician: ARCHANA SAXENA.
Sonographer: MICHAEL CHEN

Arterial Color Duplex Evaluation of the RIGHT lower extremity reveals no evidence of arterial
stenosis. Color duplex evaluation of RIGHT lower arterial system reveals:.

Arterial Color Duplex Evaluation of the LEFT lower extremity reveals no evidence of arterial
stenosis. Color duplex evaluation of LEFT lower arterial system reveals:.

RIGHT

	PSV (cm/s)	EDV (cm/s)	RI	S/D	Waveform
EIA	85.6	29.1	0.83	5.88	Triphasic
CFA	83.3	14.9	0.82	5.59	
Prof Prox	57.0	3.1	0.9	18.2	
SFA Prox	88.0	7.9	0.91	11.20	Triphasic
SFA Mid	96.6	11.8	0.88	8.19	Triphasic
SFA Dist	95.9	11.0	0.89	8.72	Triphasic
SFA MAX	96.6				Triphasic
Pop					
Pop Prox	94.3	10.2	0.89	9.25	
Pop Mid	51.9	10.2	0.80	5.09	
Pop Dist	68.4	7.9	0.89	8.70	
Pop MAX	94.3				Triphasic
Peron					
Peron MAX	48.5				
Peron Dist	48.5	10.5	0.78	4.62	Triphasic
PTA					
PTA Dist	86.6	5.5	0.94	15.72	
PTA MAX	86.6				Triphasic
ATA					
ATA Dist	84.2	6.9	0.92	12.19	
ATA MAX	84.2				

Key: CFA (common femoral artery), EIA (external iliac artery), CIA (comment iliac artery),
Peron (Peroneal), Pop (popliteal), PTA (posterior tibial artery), SFA (superficial femoral
artery), PSV (peak systolic velocity), EDV (end diastolic velocity), RI (resistive index), S/D
(systolic/diastolic)

	PSV (cm/s)	EDV (cm/s)	RI	S/D	Waveform
EIA	93.5	10.2	0.89	9.17	Triphasic
CFA	87.2	10.2	0.88	8.55	
Profunda					Triphasic
Prof Prox	60.1	5.5	0.91	10.9	
SFA Prox	94.3	11.8	0.87	7.99	Triphasic
SFA Mid	82.5	13.4	0.84	6.16	Triphasic
SFA Dist	77.0	8.6	0.89	8.91	Triphasic
SFA MAX	94.3				
Pop					Triphasic
Pop Prox	75.4	7.9	0.90	9.59	
Pop Mid	71.0	9.4	0.87	7.53	
Pop Dist	62.9	6.3	0.90	10.00	
Pop MAX	75.4				
Peron					Triphasic
Peron Dist	65.6	8.3	0.87	7.93	
Peron MAX	65.6				
PTA					Triphasic
PTA Dist	86.6	10.5	0.88	8.25	
PTA Max	86.6				
ATA					Triphasic
ATA Dist	70.0	6.1	0.91	11.53	
ATA Max	70.0				

Key: CFA (common femoral artery), EIA (external iliac artery), CIA (comment iliac artery),
Peron (Peroneal), Pop (popliteal), PTA (posterior tibial artery), SFA (superficial femoral
artery), PSV (peak systolic velocity), EDV (end diastolic velocity), RI (resistive index), S/D
(systolic/diastolic)

Electronically released/read by: George Fernaine, MD on 8/3/2020 at 11:59:33 AM

* Final *

Procedure Note

Interface, Mla In - 08/03/2020 11:59 AM EDT
NYU Langone Ambulatory Care Bay Ridge
6740 Fourth Ave, 2nd Floor, Brooklyn, NY 11220
Tel: 929.455.2740 Fax: 929.455.2750

Lower Arterial Duplex Report

Pt. Name: JOSEPH GAGLIARDO Study Date: 8/3/2020
Pt. ID: 11002267 Accession #: 20301479
DOB: 6/24/1957 EPIC Code: IMG16414
Age: 63 Height: 75 in(191 cm)
Gender: M Weight: 322 lb (146 kg)
Location: BSA: 2.69 m^2

Referring Physician: ARCHANA SAXENA.
Sonographer: MICHAEL CHEN

Arterial Color Duplex Evaluation of the RIGHT lower extremity reveals no evidence of arterial stenosis. Color duplex evaluation of RIGHT lower arterial system reveals:.

Arterial Color Duplex Evaluation of the LEFT lower extremity reveals no evidence of arterial stenosis. Color duplex evaluation of LEFT lower arterial system reveals:.

RIGHT
PSV (cm/s) EDV (cm/s) RI S/D Waveform
EIA 85.6 29.1 0.83 5.88 Triphasic
CFA 83.3 14.9 0.82 5.59
Prof Prox 57.0 3.1 0.9 18.2
SFA Prox 88.0 7.9 0.91 11.20 Triphasic
SFA Mid 96.6 11.8 0.88 8.19 Triphasic

SFA MAX 96.6
Pop Triphasic
Pop Prox 94.3 10.2 0.89 9.25
Pop Mid 51.9 10.2 0.80 5.09
Pop Dist 68.4 7.9 0.89 8.70
Pop MAX 94.3
Peron Triphasic
Peron MAX 48.5
Peron Dist 48.5 10.5 0.78 4.62
PTA Triphasic
PTA Dist 86.6 5.5 0.94 15.72
PTA MAX 86.6
ATA Triphasic
ATA Dist 84.2 6.9 0.92 12.19
ATA MAX 84.2
Key: CFA (common femoral artery), EIA (external iliac artery), CIA (comment iliac artery), Peron (Peroneal), Pop (popliteal), PTA (posterior tibial artery), SFA (superficial femoral artery), PSV (peak systolic velocity), EDV (end diastolic velocity), RI (resistive index), S/D (systolic/diastolic)

LEFT
PSV (cm/s) EDV (cm/s) RI S/D Waveform
EIA 93.5 10.2 0.89 9.17 Triphasic
CFA 87.2 10.2 0.88 8.55
Profunda Triphasic
Prof Prox 60.1 5.5 0.91 10.9
SFA Prox 94.3 11.8 0.87 7.99 Triphasic
SFA Mid 82.5 13.4 0.84 6.16 Triphasic
SFA Dist 77.0 8.6 0.89 8.91 Triphasic
SFA MAX 94.3
Pop Triphasic
Pop Prox 75.4 7.9 0.90 9.59
Pop Mid 71.0 9.4 0.87 7.53
Pop Dist 62.9 6.3 0.90 10.00
Pop MAX 75.4
Peron Triphasic
Peron Dist 65.6 8.3 0.87 7.93
Peron MAX 65.6
PTA Triphasic
PTA Dist 86.6 10.5 0.88 8.25
PTA Max 86.6
ATA Triphasic
ATA Dist 70.0 6.1 0.91 11.53
ATA Max 70.0
Key: CFA (common femoral artery), EIA (external iliac artery), CIA (comment iliac artery), Peron (Peroneal), Pop (popliteal), PTA (posterior tibial artery), SFA (superficial femoral artery), PSV (peak systolic velocity), EDV (end diastolic velocity), RI (resistive index), S/D (systolic/diastolic)

Electronically released/read by: George Fernaine, MD on 8/3/2020 at 11:59:33 AM

* Final *

Performing Organization	Address	City/State/Zipcode	Phone Number
NYU SYNGO DYNAMICS			

CT ANGIO CHEST W/IVC (CT ANGIO CHEST WITH IV CONTRAST) - Final result (07/28/2020 1:38 PM EDT)

Specimen

NYU RADIOLOGY SWF

IMPRESSION:
1. Negative for aortic dissection or dissection equivalent.
2. Questionable ectasia of the aortic root which is likely secondary to cardiac motion.
3. Significant aortic valve calcifications given the patient's age.
4. Patulous mid esophagus with retained midesophageal fluid.

Recommendations: Evaluation for possible aortic stenosis should be considered if not recently performed.

Performed At
NYU RADIOLOGY SWF

Narrative

CT AORTOGRAM OF THE CHEST

CLINICAL INDICATION: Acute nonspecific chest pain.

COMPARISON: None

TECHNIQUE: Contrast enhanced thoracic aortic CT angiogram was performed. Contrast bolus tracking utilized for timing of image acquisition. Multiplanar CT and HRCT images were reviewed. Advanced 3D reconstructions were performed on a dedicated workstation to validate aortic measurements under Concurrent Supervision. Images were acquired during the administration of 100 cc nonionic Isovue-300 IV contrast.

FINDINGS:

Support devices: Partially imaged gastric lap band.

THORACIC AORTA:
Aortic Root: Moderate aortic valve calcifications. Possible mild ectasia degraded by motion.

Ascending Aorta: No atherosclerotic disease. Normal in course and caliber allowing for motion artifact.

Aortic Arch: No atherosclerotic disease. Normal in course and caliber.

Descending Thoracic Aorta: No atherosclerotic disease. Normal in course and caliber.

Supra-renal Abdominal Aorta (imaged): Minimal aortic atherosclerotic disease. Normal in course and caliber.

Arch Vessels:
Innominate, right common carotid and right subclavian arteries: No atherosclerotic disease. Normal in course and caliber.

Left common carotid artery: No atherosclerotic disease. Normal in course and caliber.

Left subclavian artery: No atherosclerotic disease. Normal in course and caliber.

Measurements (Root and Thoracic Aorta):

Sinuses of Valsalva: 47 mm x 43 mm x 43 mm
Sinotubular junction: 36 mm
Mid-ascending aorta: 38 mm
Transverse aorta: 33 mm
Mid-descending aorta: 31 mm
Level of diaphragm: 31 mm

HEART: Normal in size. No pericardial effusion. Atherosclerotic calcifications of the coronary arteries are present.

NON-CARDIOVASCULAR:
LUNGS: Normal, without nodules, masses or opacities.

AIRWAYS: Normal and without tracheal or bronchial lesion.

PLEURA and DIAPHRAGM: No pleural effusions. No pneumothorax.

MEDIASTINUM, HILA, LYMPH NODES: No adenopathy. Scattered subcentimeter lymph nodes are present in the mediastinum and axilla.

ENTERIC TRACT (thoracic): Mildly patulous mid and lower esophagus. Fluid is retained in the midesophagus.

SOFT TISSUES: Normal.

BONES: No suspicious sclerotic or lytic osseous lesions. Moderate degenerative changes throughout the included spine.

LOWER NECK: Normal.

Electronic Signature: I personally reviewed the images and agree with this report.
Final Report: Dictated by and Signed by Attending Elliott Gozansky MD 7/28/2020 2:43 PM

Procedure Note

Interface, Rad In - 07/28/2020 2:46 PM EDT

CT AORTOGRAM OF THE CHEST

CLINICAL INDICATION: Acute nonspecific chest pain.

COMPARISON: None

TECHNIQUE: Contrast enhanced thoracic aortic CT angiogram was performed. Contrast bolus tracking utilized for timing of im acquisition. Multiplanar CT and HRCT images were reviewed. Advanced 3D reconstructions were performed on a dedicated workstation to validate aortic measurements under Concurrent Supervision. Images were acquired during the administration o cc nonionic Isovue-300 IV contrast.

FINDINGS:

Support devices: Partially imaged gastric lap band.

THORACIC AORTA:
Aortic Root: Moderate aortic valve calcifications. Possible mild ectasia degraded by motion.

Ascending Aorta: No atherosclerotic disease. Normal in course and caliber allowing for motion artifact.

Aortic Arch: No atherosclerotic disease. Normal in course and caliber.

Descending Thoracic Aorta: No atherosclerotic disease. Normal in course and caliber.

Supra-renal Abdominal Aorta (imaged): Minimal aortic atherosclerotic disease. Normal in course and caliber.

Arch Vessels:
Innominate, right common carotid and right subclavian arteries: No atherosclerotic disease. Normal in course and caliber.

Left common carotid artery: No atherosclerotic disease. Normal in course and caliber.

Left subclavian artery: No atherosclerotic disease. Normal in course and caliber.

Measurements (Root and Thoracic Aorta):

Sinuses of Valsalva: 47 mm x 43 mm x 43 mm
Sinotubular junction: 36 mm
Mid-ascending aorta: 38 mm
Transverse aorta: 33 mm
Mid-descending aorta: 31 mm
Level of diaphragm: 31 mm

HEART: Normal in size. No pericardial effusion. Atherosclerotic calcifications of the coronary arteries are present.

NON-CARDIOVASCULAR:
LUNGS: Normal, without nodules, masses or opacities.

AIRWAYS: Normal and without tracheal or bronchial lesion.

PLEURA and DIAPHRAGM: No pleural effusions. No pneumothorax.

axilla.

ENTERIC TRACT (thoracic): Mildly patulous mid and lower esophagus. Fluid is retained in the midesophagus.

UPPER ABDOMEN: The included solid and hollow viscera are normal. No pneumoperitoneum. No ascites. No lymph node enlargement.

SOFT TISSUES: Normal.

BONES: No suspicious sclerotic or lytic osseous lesions. Moderate degenerative changes throughout the included spine.

LOWER NECK: Normal.

Electronic Signature: I personally reviewed the images and agree with this report. Final Report: Dictated by and Signed by Attend
Elliott Gozansky MD 7/28/2020 2:43 PM

IMPRESSION:
1. Negative for aortic dissection or dissection equivalent.
2. Questionable ectasia of the aortic root which is likely secondary to cardiac motion.
3. Significant aortic valve calcifications given the patient's age.
4. Patulous mid esophagus with retained midesophageal fluid.

Recommendations: Evaluation for possible aortic stenosis should be considered if not recently performed.

Performing Organization	Address	City/State/Zipcode	Phone Number
NYU RADIOLOGY SWF			

EKG 12-LEAD - Final result (07/22/2020 11:37 AM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
EKG 12-LEAD	Ventricular Rate: 60 BPM Atrial Rate: 60 BPM P-R Interval: 246 ms QRS Duration: 122 ms Q-T Interval: 388 ms QTC Calculation(Bezet): 388 ms P Axis: 23 degrees R Axis: -31 degrees T Axis: 6 degrees Sinus rhythm with 1st degree A-V block Left axis deviation Left ventricular hypertrophy with QRS widening T wave abnormality, consider lateral ischemia Abnormal ECG		MUSE	

Specimen

Performing Organization	Address	City/State/Zipcode	Phone Number
MUSE			

ECHOCARDIOGRAM TRANSTHORACIC, COMPLETE (ECHOCARDIOGRAM TRANSTHORACIC COMPLETE) - Final re
(07/17/2020 3:35 PM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signatu
LV Fraction	70.0		NYU SYNCO	

Aortic regurgitation	mild	NYU SYNGO DYNAMICS
Mitral regurgitation	none	NYU SYNGO DYNAMICS
Tricuspid regurgitation	trace	NYU SYNGO DYNAMICS
Pulmonic regurgitation	trace	NYU SYNGO DYNAMICS

Specimen

Performed At
NYU SYNGO DYNAMI

Impressions

CONCLUSION:
--Technically difficult study.
--There is mild left atrial dilatation (LA volume index 40 ml/m²).
--There is moderate left ventricular hypertrophy.
--LV global wall motion is probably normal.
--LV ejection fraction (70 %) is normal.
--The left ventricular filling pattern is normal.
--The right ventricle is normal in size. The right ventricle has normal wall motion.
--The aortic root is moderately dilated (4.80 cm). Ascending aorta is normal in size; its
diameter is 3.50 cm (1.3 cm/m²).
--The aortic valve is calcified. There is no aortic stenosis. There is mild aortic regurgitation.
--There is mitral annular calcification. There is no mitral stenosis. There is no mitral
regurgitation.
--The right atrial pressure is normal (0 - 5 mm Hg). There is too little tricuspid regurgitation to estimate PA systolic pressure.
--There is no pericardial effusion.
--No prior TTE available for comparison.

Performed At
NYU SYNGO DYNAM

Narrative

NYU Langone Ambulatory Care Bay Ridge
6740 Fourth Ave, 2nd Floor, Brooklyn, NY 11220
Tel: 929.455.2740 Fax: 929.455.2750

2D Transthoracic Echo Report

Pt. Name:	JOSEPH GAGLIARDO	Study Date:	7/17/2020
Pt. ID:	11002267	Accession #:	20012511
DOB:	6/24/1957	EPIC Code:	ECH10
Age:	63	Height:	72 in(183 cm)
Gender:	M	Weight:	323 lb (147 kg)
Location:		BSA:	2.61 m²

Referring Physician: ARCHANA SAXENA.
Sonographer: CHRISTINA ALVAREZ

Indication: Dyspnea on exertion.

MEASUREMENTS:

	Value	Normal		Value	Normal
Aortic Root	4.8 cm	<4.6 cm	LVOT Diameter	3.00 cm	
LA Diameter		<3.8 (<4.0)	LVOT Area	7.07 cm²	
LA Vol Index	40 ml/m²	<34	LVOT Stroke Volume		
			LVOT Vmax (rest)		
IV Septum	1.4 cm	<1.1 (<1.2)	LVOT dPmax(rest)		
LVEDD	4.7 cm	<5.3	LVOT Vmax		

Wall		(<1.2)	(Vad)		
LVESD	3.5 cm				
LVED Vol	48 ml/m²	<75	AV Vmax		1.0-1.7
Index			AV Peak Gradient		
LV Mass	107 g/m²	<95	AV Mean Gradient		
Index		(<115)	AV Area		2-4
LVEF	70 %	50-70%	Impedance (Zva)		<3.5
			Aortic Regurge P 1/2		
RAP, mean	5 mmHg	0-5			
PASP		<35			
PADP		<15			
RV-RA					
PA-RV			MV E wave Vmax	0.8 m/s	0.6-1.3
LA, mean		<12	MV Mean Gradient		
			MV Area		4-6
Mitral E	84 cm/s				
Mitral A	94 cm/s				
Mitral E/A	0.9				
Decel Time	246 msec		TV E wave Vmax		0.3-0.7
Mitral P 1/2	71 msec		TV Mean Gradient		
E' (medial)		>8			
E' (lateral)		>8			
E/E'		<8	RVOT Diameter	3.0 cm	
PV S/D			RVOT Area	7.07 cm²	
			RVOT Stroke Volume		
			RVOT Vmax		
			PV Vmax		0.6-0.9
			PV Peak Gradient		
			BP	131/72 mmHg	
			HR	71 bpm	

Normal values in parentheses are specific for men;
normal arotic root values adjusted for age and BSA.
LLAVI data reflect 2015 ASE guidelines.

TECHNIQUE:
Complete 2D transthoracic echocardiogram with color and spectral Doppler was performed.

FINDINGS:
Left Heart:
--There is mild left atrial dilatation (LA volume index 40 ml/m²).
--The interventricular septum is moderately hypertrophied. The inferolateral (posterior) wall
is moderately hypertrophied. There is no asymmetric septal hypertrophy. There is moderate left
ventricular hypertrophy. The left ventricle has normal end-diastolic diameter.
--LV global wall motion is probably normal. LV ejection fraction (70 %) is normal.
--The left ventricular filling pattern is normal.
Mitral Valve:
--There is mitral annular calcification. There is no mitral stenosis. There is no mitral
regurgitation.
Aortic Valve:
--The aortic valve is calcified. Aortic valve is trileaflet. There is no aortic stenosis. There
is mild aortic regurgitation.
Aorta:
--The aortic root is moderately dilated. Ascending aorta is normal in size; its diameter is
3.50 cm (1.3 cm/m²).
Right Heart and Systemic Veins:
--There is no right atrial dilatation

right
ventricle has normal wall motion.
--The right atrial pressure is normal (0 - 5 mm Hg). There is too little tricuspid
regurgitation to estimate PA systolic pressure.
Tricuspid Valve:
--The tricuspid valve is normal. There is no tricuspid stenosis. There is trace
tricuspid
regurgitation.
Pulmonic Valve:
--The pulmonic valve is normal. There is trace pulmonic regurgitation.
Pericardium and Effusions: --There is no pericardial effusion.

CONCLUSION:
--Technically difficult study.
--There is mild left atrial dilatation (LA volume index 40 ml/m²).
--There is moderate left ventricular hypertrophy.
--LV global wall motion is probably normal.
--LV ejection fraction (70 %) is normal.
--The left ventricular filling pattern is normal.
--The right ventricle is normal in size. The right ventricle has normal wall motion.
--The aortic root is moderately dilated (4.80 cm). Ascending aorta is normal in size;
its
diameter is 3.50 cm (1.3 cm/m²).
--The aortic valve is calcified. There is no aortic stenosis. There is mild aortic
regurgitation.
--There is mitral annular calcification. There is no mitral stenosis. There is no
mitral
regurgitation.
--The right atrial pressure is normal (0 - 5 mm Hg). There is too little tricuspid
regurgitation to estimate PA systolic pressure.
--There is no pericardial effusion.
--No prior TTE available for comparison.

Electronically released/read by: Robert Zaloom, MD on 7/17/2020 at 4:05:47 PM

* Final *

Procedure Note

Interface, Mla In - 07/17/2020 4:05 PM EDT
NYU Langone Ambulatory Care Bay Ridge
6740 Fourth Ave, 2nd Floor, Brooklyn, NY 11220
Tel: 929.455.2740 Fax: 929.455.2750

2D Transthoracic Echo Report

Pt. Name: JOSEPH GAGLIARDO Study Date: 7/17/2020
Pt. ID: 11002267 Accession #: 20012511
DOB: 6/24/1957 EPIC Code: ECH10
Age: 63 Height: 72 in(183 cm)
Gender: M Weight: 323 lb (147 kg)
Location: BSA: 2.61 m²

Referring Physician: ARCHANA SAXENA.
Sonographer: CHRISTINA ALVAREZ

Indication: Dyspnea on exertion.

MEASUREMENTS:
Value Normal Value Normal
Aortic Root 4.8 cm <4.6 cm LVOT Diameter 3.00 cm
LA Diameter <3.8 LVOT Area 7.07

Index Volume
---------- LVOT Vmax
(rest)
IV Septum 1.4 cm <1.1 LVOT
(<1.2) dPmax(rest)
LVEDD 4.7 cm <5.3 LVOT Vmax
(<6.0) (Vals)
Inf-Lat 1.4 cm <1.1 LVOT dPmax
Wall (<1.2) (Vals)
LVESD 3.5 cm ----------

LVED Vol 48 ml/m^2 <75 AV Vmax 1.0-1.7
Index AV Peak
LV Mass 107 g/m^2 <95 Gradient
Index (<115) AV Mean
---------- Gradient
AV Area 2-4
LVEF 70 % 50-70% Impedance <3.5
---------- (Zva)
Aortic Regurge
RAP, mean 5 mmHg 0-5 P 1/2
PASP <35 ----------
PADP <15
RV-RA
PA-RV MV E wave Vmax 0.8 m/s 0.6-1.3
LA, mean <12 MV Mean
---------- Gradient
MV Area 4-6
Mitral E 84 cm/s ----------
Mitral A 94 cm/s
Mitral E/A 0.9
Decel Time 246 msec TV E wave Vmax 0.3-0.7
Mitral P 71 msec TV Mean
1/2 Gradient
E' (medial) >8 ----------
E' >8
(lateral)
E/E' <8 RVOT Diameter 3.0 cm
PV S/D RVOT Area 7.07
Normal values in parentheses are cm^2
specific for men; RVOT Stroke
normal arotic root values adjusted Volume
for age and BSA. RVOT Vmax
LLAVI data reflect 2015 ASE ----------
guidelines.

PV Vmax 0.6-0.9
PV Peak
Gradient

BP 131/72
mmHg
HR 71 bpm

TECHNIQUE:
Complete 2D transthoracic echocardiogram with color and spectral Doppler was performed.

Left Heart:
--There is mild left atrial dilatation (LA volume index 40 ml/m^2).
--The interventricular septum is moderately hypertrophied. The inferolateral (posterior) wall is moderately hypertrophied. There is no asymmetric septal hypertrophy. There is moderate left ventricular hypertrophy. The left ventricle has normal end-diastolic diameter.
--LV global wall motion is probably normal. LV ejection fraction (70 %) is normal.
--The left ventricular filling pattern is normal.
Mitral Valve:
--There is mitral annular calcification. There is no mitral stenosis. There is no mitral regurgitation.
Aortic Valve:
--The aortic valve is calcified. Aortic valve is trileaflet. There is no aortic stenosis. There is mild aortic regurgitation.
Aorta:
--The aortic root is moderately dilated. Ascending aorta is normal in size; its diameter is 3.50 cm (1.3 cm/m^2).
Right Heart and Systemic Veins:
--There is no right atrial dilatation.
--There is no right ventricular hypertrophy. The right ventricle is normal in size. The right ventricle has normal wall motion.
--The right atrial pressure is normal (0 - 5 mm Hg). There is too little tricuspid regurgitation to estimate PA systolic pressure.
Tricuspid Valve:
--The tricuspid valve is normal. There is no tricuspid stenosis. There is trace tricuspid regurgitation.
Pulmonic Valve:
--The pulmonic valve is normal. There is trace pulmonic regurgitation.
Pericardium and Effusions: --There is no pericardial effusion.

CONCLUSION:
--Technically difficult study.
--There is mild left atrial dilatation (LA volume index 40 ml/m^2).
--There is moderate left ventricular hypertrophy.
--LV global wall motion is probably normal.
--LV ejection fraction (70 %) is normal.
--The left ventricular filling pattern is normal.
--The right ventricle is normal in size. The right ventricle has normal wall motion.
--The aortic root is moderately dilated (4.80 cm). Ascending aorta is normal in size; its diameter is 3.50 cm (1.3 cm/m^2).
--The aortic valve is calcified. There is no aortic stenosis. There is mild aortic regurgitation.
--There is mitral annular calcification. There is no mitral stenosis. There is no mitral regurgitation.
--The right atrial pressure is normal (0 - 5 mm Hg). There is too little tricuspid regurgitation to estimate PA systolic pressure.
--There is no pericardial effusion.
--No prior TTE available for comparison.

Electronically released/read by: Robert Zaloom, MD on 7/17/2020 at 4:05:47 PM

* Final *
IMPRESSION
CONCLUSION:
--Technically difficult study.
--There is mild left atrial dilatation (LA volume index 40 ml/m^2).
--There is moderate left ventricular hypertrophy.
--LV global wall motion is probably normal.
--LV ejection fraction (70 %) is normal.
--The left ventricular filling pattern is normal.
--The right ventricle is normal in size. The right ventricle has normal wall motion.
--The aortic root is moderately dilated (4.80 cm). Ascending aorta is normal in size; its diameter is 3.50 cm (1.3 cm/m^2).

--There is mitral annular calcification. There is no mitral stenosis. There is no mitral regurgitation.
--The right atrial pressure is normal (0 - 5 mm Hg). There is too little tricuspid regurgitation to estimate PA systolic pressure.
--There is no pericardial effusion.
--No prior TTE available for comparison.

Performing Organization	Address	City/State/Zipcode	Phone Number
NYU SYNGO DYNAMICS			

US DUPLEX CAROTID ARTERIES BILATERAL - Final result (07/17/2020 2:45 PM EDT)

Specimen

Performed At: NYU SYNGO DYNAMIC

Narrative

NYU Langone Ambulatory Care Bay Ridge
6740 Fourth Ave, 2nd Floor, Brooklyn, NY 11220
Tel: 929.455.2740 Fax: 929.455.2750

Carotid Duplex Report

Pt. Name:	JOSEPH GAGLIARDO	Study Date:	7/17/2020
Pt. ID:	11002267	Accession #:	20012513
DOB:	6/24/1957	EPIC Code:	IMG11631
Age:	63	Height:	72 in(183 cm)
Gender:	M	Weight:	323 lb (147 kg)
Location:		BSA:	2.61 m²

Referring Physician: ARCHANA SAXENA.
Sonographer: JOSEPHINE NASTASE

Indication: Bruit.
History:
Study Quality:

RIGHT Systole (cm/s)	RIGHT Diastole (cm/s)	% Stenosis	RESULTS	LEFT Systole (cm/s)	LEFT Diastole (cm/s)	% Stenosis
0	0		Proximal ICA	0	0	
0	0		Mid ICA	0	0	
1	0		Distal ICA	1	0	
68	15		Proximal CCA	90	16	
58	12		Distal CCA	68	16	
94	19		ECA	97	17	
1	0		Vertebral Artery	0	0	

Right:
There is no hemodynamically significant ICA flow disturbance or stenosis. There is antegrade
flow in the right vertebral artery.

Left:
There is no hemodynamically significant ICA flow disturbance or stenosis. There is antegrade
flow in the left vertebral artery.

Impression:
1. No stenosis is noted in the internal carotid arteries bilaterally
2. Both vertebral arteries show normal antegrade flow

Electronically released/read by: Thao Ngo, MD on 7/17/2020 at 4:35:07 PM

* Final *

Procedure Note

Interface, Mla In - 07/17/2020 4:35 PM EDT
NYU Langone Ambulatory Care Bay Ridge
6740 Fourth Ave, 2nd Floor, Brooklyn, NY 11220
Tel: 929.455.2740 Fax: 929.455.2750

Carotid Duplex Report

Pt. Name: JOSEPH GAGLIARDO Study Date: 7/17/2020
Pt. ID: 11002267 Accession #: 20012513
DOB: 6/24/1957 EPIC Code: IMG11631
Age: 63 Height: 72 in(183 cm)
Gender: M Weight: 323 lb (147 kg)
Location: BSA: 2.61 m^2

Referring Physician: ARCHANA SAXENA.
Sonographer: JOSEPHINE NASTASE

Indication: Bruit.
History:
Study Quality:

	RIGHT			LEFT	
Systole (cm/s)	Diastole (cm/s)	% Stenosis	RESULTS	Systole (cm/s)	Diastole (cm/s)	% Stenosis
0	0	Proximal		0	0	
ICA						
0	0	Mid ICA		0	0	
1	0	Distal ICA		1	0	
68	15	Proximal		90	16	
CCA						
58	12	Distal CCA		68	16	
94	19	ECA		97	17	
1	0	Vertebral		0	0	
Artery						

Right:
There is no hemodynamically significant ICA flow disturbance or stenosis. There is antegrade flow in the right vertebral artery.

Left:
There is no hemodynamically significant ICA flow disturbance or stenosis. There is antegrade flow in the left vertebral artery.

Impression:
1. No stenosis is noted in the internal carotid arteries bilaterally
2. Both vertebral arteries show normal antegrade flow

Electronically released/read by: Thao Ngo, MD on 7/17/2020 at 4:35:07 PM

* Final *

Performing Organization	Address	City/State/Zipcode	Phone Number
NYU SYNGO DYNAMICS			

NM NUCLEAR STRESS TEST PHARMACOLOGIC - Final result (07/14/2020 10:15 AM EDT)

Specimen

Performed At
NYU SYNGO DYNAMICS

Narrative

This result has an attachment that is not available.
· No ECG evidence of ischemia after administration of IV regadenoson.
· Post stress resting myocardial perfusion gated SPECT imaging was performed, showing a left ventricular ejection fraction of 44.
· Gated imaging showed mild global hypokinesis.
· SPECT results show no clear scintigraphic scan evidence of significant myocardial ischemia or infarct
· Summary: Left ventricular perfusion is normal with post stress left ventricular gated ejection fraction of 44%.

Procedure Note

Bustros, Thomas, MD - 07/14/2020 4:36 PM EDT
· No ECG evidence of ischemia after administration of IV regadenoson.
· Post stress resting myocardial perfusion gated SPECT imaging was performed, showing a left ventricular ejection fraction of 4
· Gated imaging showed mild global hypokinesis.
· SPECT results show no clear scintigraphic scan evidence of significant myocardial ischemia or infarct
· Summary: Left ventricular perfusion is normal with post stress left ventricular gated ejection fraction of 44%.

Performing Organization	Address	City/State/Zipcode	Phone Number
NYU SYNGO DYNAMICS			

US DOPPLER ARTERIAL PVR NON STRESS - Final result (07/07/2020 3:00 PM EDT)

Specimen

Performed At
NYU SYNGO DYNAMI

Narrative

NYU Langone Ambulatory Care Bay Ridge
6740 Fourth Ave, 2nd Floor, Brooklyn, NY 11220
Tel: 929.455.2740 Fax: 929.455.2750

Arterial Physiologic Testing

Pt. Name:	JOSEPH GAGLIARDO	Study Date:	7/7/2020
Pt. ID:	11002267	Accession #:	20012512
DOB:	6/24/1957	EPIC Code:	IMG16149
Age:	63	Height:	( )
Gender:	M	Weight:	323 lb (147 kg)
Location:		BSA:	2.78 m²

Referring Physician: ARCHANA SAXENA.
Technologist: Elba Mendez Dominguez

Indications: LE pain, numbness

	Right		Left
Pressures (mmHg)		Pressures (mmHg)	
PVR Waveforms		PVR Waveforms	
High Thigh	Normal	High Thigh	Normal
Above Knee	Normal	Above Knee	Normal
Calf	Normal	Calf	Normal
Ankle	Normal	Ankle	Normal

Toe Normal Toe Normal

Interpretation:
The right Ankle/Brachial Index is 1.46. The right Toe/Brachial Index is 0.88.
The left Ankle/Brachial Index is 1.51. The left Toe/Brachial Index is 0.87.
Elevated ABI noted bilaterally which may suggest calcification of the lower extremity arteries

Electronically released/read by: Thao Ngo, MD on 7/7/2020 at 6:10:52 PM

* Final *

Procedure Note

Interface, Mla In - 07/07/2020 6:10 PM EDT
NYU Langone Ambulatory Care Bay Ridge
6740 Fourth Ave, 2nd Floor, Brooklyn, NY 11220
Tel: 929.455.2740 Fax: 929.455.2750

Arterial Physiologic Testing

Pt. Name: JOSEPH GAGLIARDO Study Date: 7/7/2020
Pt. ID: 11002267 Accession #: 20012512
DOB: 6/24/1957 EPIC Code: IMG16149
Age: 63 Height: ( )
Gender: M Weight: 323 lb (147 kg)
Location: BSA: 2.78 m^2

Referring Physician: ARCHANA SAXENA.
Technologist: Elba Mendez Dominguez

Indications: LE pain, numbness

Right Pressures (mmHg)		Left Pressures (mmHg)
PVR Waveforms		PVR Waveforms
High Thigh	Normal	High Thigh Normal
Above Knee	Normal	Above Knee Normal
Calf	Normal	Calf Normal
Ankle	Normal	Ankle Normal
Metatarsal	Normal	Metatarsal Normal
Toe	Normal	Toe Normal

Interpretation:
The right Ankle/Brachial Index is 1.46. The right Toe/Brachial Index is 0.88.
The left Ankle/Brachial Index is 1.51. The left Toe/Brachial Index is 0.87.
Elevated ABI noted bilaterally which may suggest calcification of the lower extremity arteries

Electronically released/read by: Thao Ngo, MD on 7/7/2020 at 6:10:52 PM

* Final *

Performing Organization Address City/State/Zipcode Phone Number

NYU LANGONE DYNAMICS

HOLTER MONITOR (HOLTER MONITOR - 24 TO 48 HOURS) - Final result (07/07/2020)

Performed At

Narrative

This result has an attachment that is not available.

Performing Organization	Address	City/State/Zipcode	Phone Number
NYU PERFORMED			

CBC WITH DIFFERENTIAL - Edited Result - FINAL (06/23/2020 2:45 PM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
WHITE BLOOD CELL COUNT	5.9	3.6 - 11.0 THDS/CMM	SUNRISE	
RED BLOOD CELL COUNT	5.30	4.40 - 6.10 MILL/CMM	SUNRISE	
HEMOGLOBIN	15.0	13.0 - 18.0 G/DL	SUNRISE	
HEMATOCRIT	44.4	39 - 52 %	SUNRISE	
MEAN CORPUSCULAR VOLUME	84	75 - 100 fL	SUNRISE	
MEAN CORPUSCULAR HEMOGLOBIN	28.3	26.0 - 32.0 pg	SUNRISE	
MEAN CORPUSCULAR HEMOGLOBIN CONC	33.8	32.0 - 35.0 g/dl	SUNRISE	
RED CELL DISTRIBUTION WIDTH	13.3	11.2 - 14.8 %	SUNRISE	
PLATELET COUNT	184	140 - 440 THOUS/CMM	SUNRISE	
POLYS	61.4	45 - 75 %	SUNRISE	
LYMPHOCYTES %	27.3	20 - 45 %	SUNRISE	
MONOCYTES %	9.0	0 - 13 %	SUNRISE	
EOSINOPHILS %	1.4	0 - 5 %	SUNRISE	
BASOPHILS %	0.7	0 - 2 %	SUNRISE	
IMMATURE GRANULOCYTES	0.2	0 - 2 %	SUNRISE	
NEUTROPHILS ABSOLUTE	3.60	1.9 - 8.0 K/uL	SUNRISE	
ABSOLUTE LYMPHS	1.60	0.9 - 5.2 K/uL	SUNRISE	
MONOCYTES ABSOLUTE	0.53	0.1 - 1.0 K/uL	SUNRISE	
EOSINOPHILS, ABSOLUTE	0.08	0.0 - 0.80 K/uL	SUNRISE	
BASOPHILS ABSOLUTE	0.04	0.0 - 0.2 K/uL	SUNRISE	
ABSOLUTE IMMATURE GRANULOCYTES	0.01	0.00 - 0.06 K/uL	SUNRISE	

Specimen

blood - Peripheral vein

Performing Organization	Address	City/State/Zipcode	Phone Number

COMPREHENSIVE METABOLIC PANEL - Final result (06/23/2020 2:45 PM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
GLUCOSE	100	70 - 100 mg/dL	SUNRISE	
BLOOD UREA NITROGEN	21	8 - 23 mg/dL	SUNRISE	
SODIUM	143	135 - 148 mmol/L	SUNRISE	
CREATININE	1.19	0.40 - 1.40 mg/dL	SUNRISE	
GFR CALCULATION(CKD-EPI)	65	>59 ml/min/1.73m2	SUNRISE	
GFR IN AFRICAN AMERICAN(CKD-EPI)	75	>59	SUNRISE	
POTASSIUM	4.3	3.5 - 5.4 mmol/L	SUNRISE	
CHLORIDE	106	96 - 107 mmol/L	SUNRISE	
CARBON DIOXIDE	26	18 - 32 mmol/L	SUNRISE	
CALCIUM	10.1	8.6 - 10.5 mg/dL	SUNRISE	
PROTEIN, TOTAL	7.1	6.0 - 8.3 g/dL	SUNRISE	
ALBUMIN	4.9	3.5 - 5.2 g/dL	SUNRISE	
GLOBULIN	2.2	1.8 - 3.8 g/dL	SUNRISE	
A/G RATIO	2.2	1.0 - 2.5 RATIO	SUNRISE	
ALKALINE PHOSPHATASE	71	39 - 118 U/L	SUNRISE	
AST	38	9 - 50 U/L	SUNRISE	
ALT	31	5 - 50 U/L	SUNRISE	
BILIRUBIN TOTAL	0.7	<1.3 mg/dL	SUNRISE	

Specimen

blood - Peripheral vein

Performing Organization	Address	City/State/Zipcode	Phone Number
SUNRISE			

XR KNEE BILATERAL 1 OR 2 VW (XR KNEE AP AND LATERAL BILATERAL) - Final result (06/23/2020 2:38 PM EDT

Specimen

Performed At

NYU RADIOLOGY

Impressions

IMPRESSION:

No acute fracture or dislocation. Mild medial femoral tibial joint space narrowing in both knees with mild tricompartmental osteophyte formation compatible with mild osteoarthrosis. There are large superior and inferior patellar enthesophytes bilaterally as well as large anterior tibial tubercle enthesophytes bilaterally. No significant effusion in either knee

Performed At

NYU RADIOLOGY

Narrative

History: Osteoarthrosis

Technique: XR KNEE AP AND LATERAL BILATERAL

Comparison: None available

Electronic Signature: I personally reviewed the images and agree with this report.
Final Report: Dictated by and Signed by Attending MICHAEL B. MECHLIN MD 6/23/2020 4:28 PM

Procedure Note

History: Osteoarthrosis

Technique: XR KNEE AP AND LATERAL BILATERAL

Comparison: None available

Electronic Signature: I personally reviewed the images and agree with this report. Final Report: Dictated by and Signed by Attend
MICHAEL B. MECHLIN MD 6/23/2020 4:28 PM

IMPRESSION:

No acute fracture or dislocation. Mild medial femoral tibial joint space narrowing in both knees with mild tricompartmental osteophyte formation compatible with mild osteoarthrosis. There are large superior and inferior patellar enthesophytes bilatera as well as large anterior tibial tubercle enthesophytes bilaterally. No significant effusion in either knee

Performing Organization	Address	City/State/Zipcode	Phone Number
NYU RADIOLOGY SWF			

XR HAND BILATERAL 2 VW (XR HAND PA AND LATERAL BILATERAL) - Final result (06/23/2020 2:38 PM EDT)

Specimen

Performed At
NYU RADIOLOGY SW

Impressions

IMPRESSION:

No acute fracture or dislocation. There is deformity of the right fifth metacarpal shaft related to an old healed fracture there. There is some deformity of the dorsal aspect of the base of the right second distal phalanx at the right second DIP joint which is probably due to old trauma. There is marked arthrosis at the basal joints of the thumb bilaterally.
Joint spaces are otherwise well preserved without significant narrowing, erosive, or osteophytic change.

Performed At
NYU RADIOLOGY SW

Narrative

History: Osteoarthrosis

Technique: XR HAND PA AND LATERAL BILATERAL

Comparison: None available

Electronic Signature: I personally reviewed the images and agree with this report. Final Report: Dictated by and Signed by Attending MICHAEL B. MECHLIN MD 6/23/2020 4:18 PM

Procedure Note

Interface, Rad In - 06/23/2020 4:20 PM EDT

History: Osteoarthrosis

Technique: XR HAND PA AND LATERAL BILATERAL

Comparison: None available

Electronic Signature: I personally reviewed the images and agree with this report. Final Report: Dictated by and Signed by A
MICHAEL B. MECHLIN MD 6/23/2020 4:18 PM

IMPRESSION:

No acute fracture or dislocation. There is deformity of the right fifth metacarpal shaft related to an old healed fracture ther
is some deformity of the dorsal aspect of the base of the right second distal phalanx at the right second DIP joint which is
due to old trauma. There is marked arthrosis at the basal joints of the thumb bilaterally.
Joint spaces are otherwise well preserved without significant narrowing, erosive, or osteophytic change.

NYU RADIOLOGY SWF

XR SCAPULA LEFT (XR SHOULDER AP AND SCAPULA LEFT) - Final result (06/23/2020 2:38 PM EDT)

Specimen

Impressions — Performed At: NYU RADIOLOGY SWF

IMPRESSION:

No acute fracture or dislocation. Mild left glenohumeral osteoarthrosis with left glenohumeral joint space narrowing, subchondral sclerosis and some osteophytic change inferiorly. Moderate arthrosis at the left AC joint.

Narrative — Performed At: NYU RADIOLOGY SWF

History: Left shoulder pain. Osteoarthritis

Technique: XR SHOULDER AP AND SCAPULA Y LEFT

Comparison: None available

Electronic Signature: I personally reviewed the images and agree with this report. Final Report: Dictated by and Signed by Attending MICHAEL B. MECHLIN MD 6/23/2020 4:40 PM

Procedure Note

Interface, Rad In - 06/23/2020 4:42 PM EDT

History: Left shoulder pain. Osteoarthritis

Technique: XR SHOULDER AP AND SCAPULA Y LEFT

Comparison: None available

Electronic Signature: I personally reviewed the images and agree with this report. Final Report: Dictated by and Signed by Att
MICHAEL B. MECHLIN MD 6/23/2020 4:40 PM

IMPRESSION:

No acute fracture or dislocation. Mild left glenohumeral osteoarthrosis with left glenohumeral joint space narrowing, subcho
sclerosis and some osteophytic change inferiorly. Moderate arthrosis at the left AC joint.

Performing Organization	Address	City/State/Zipcode	Phone Number
NYU RADIOLOGY SWF			

EKG 12-LEAD - Final result (06/15/2020 5:18 PM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signa
EKG 12-LEAD	Ventricular Rate: 65 BPM Atrial Rate: 65 BPM P-R Interval: 236 ms QRS Duration: 108 ms Q-T Interval: 382 ms QTC Calculation(Bezet): 397 ms P Axis: 60 degrees R Axis: -31 degrees T Axis: 48 degrees Sinus rhythm with 1st degree A-V block Left axis deviation Moderate voltage criteria for LVH, may be normal variant		MUSE	

Specimen

Performing Organization	Address	City/State/Zipcode	Phone Number
MUSE			

MRI PROSTATE W&WO IVC (MRI PROSTATE WITH AND WITHOUT IV CONTRAST) - Final result (06/11/2020 1:55 PM EDT)

Specimen

Impressions — Performed At: NYU RADIOLOGY SWF

IMPRESSION:

19 x 11 mm left posteromedial apex peripheral zone lesion. PI-RADS 4, high (clinically significant cancer likely). Overlying capsular irregularity without gross EPE

No evidence of seminal vesicle invasion or enlarged pelvic lymph nodes.

Narrative — Performed At: NYU RADIOLOGY SWF

MRI Prostate with and without intravenous contrast

INDICATION: Prostate biopsy on 2018 demonstrating Gleason score 3+3 tumor on the left.
PSA: 6.5

TECHNIQUE: Multi-parametric 3.0 Tesla pelvic phased-array coil MRI was performed, including multiplanar T2-weighted images, diffusion-weighted images (including high b-1500 images and ADC map), and dynamic contrast-enhanced images of the prostate. In-and-opposed-phase T1-weighted images and pre- and post-contrast T1-weighted images of the entire pelvis were also obtained.

Contrast: 14.9 ml of Gadavist was administered.

COMPARISON: Prostate MRI dated 4/3/2019.

FINDINGS:

Prostate size: 5.4 [CC] x 4.2 [AP] x 5.4 [transverse] cm for an overall volume of 64 cc.
Intra-vesical protrusion: None

Peripheral zone hemorrhage: None

Lesion localization:

LESION: 1
PI-RADS Assessment Category: 4, High (clinically significant cancer likely)
T2-weighted images: 3 (Heterogeneous or non-circumscribed round moderate hypointensity)
Diffusion-weighted images: 4 (focal marked decreased ADC & marked increased high b-value signal; <1.5 cm)
Dynamic post-contrast images: (+) focal AND earlier than or contemporaneously with enhancement of adjacent normal prostatic tissue AND corresponds to suspicious finding on T2WI and/or DWI
Size: 19 x 11 mm as measured on image 8 of series 13 (Dynamic post-contrast image)
Side: Left
Location within transverse plane: Posteromedial
Level of prostate: Apex
Zone: Peripheral
Extra-prostatic extension: Overlying capsular irregularity without gross EPE

Additional peripheral zone findings: None
Additional transition zone findings: Enlarged and heterogeneous in appearance, consistent with BPH.

Extraprostatic extension: See above.

Seminal vesicle invasion: No evidence of seminal vesicle invasion.

Lymph nodes: No pathologic pelvic lymph nodes.

Osseous structures: No aggressive osseous lesion.

Additional findings: Fat-containing right inguinal hernia.

Electronic Signature: I personally reviewed the images and agree with this report.
Final Report: Dictated by Fellow Soumya Vig MD and Signed by Attending Andrew Rosenkrantz MD 6/11/2020 3:08 PM

Procedure Note

Interface, Rad In - 06/11/2020 3:10 PM EDT

MRI Prostate with and without intravenous contrast

INDICATION: Prostate biopsy on 2018 demonstrating Gleason score 3+3 tumor on the left. PSA: 6.5

TECHNIQUE: Multi-parametric 3.0 Tesla pelvic phased-array coil MRI was performed, including multiplanar T2-weighted images diffusion-weighted images (including high b-1500 images and ADC map), and dynamic contrast-enhanced images of the prosta In-and-opposed-phase T1-weighted images and pre- and post-contrast T1-weighted images of the entire pelvis were also obtained.

Contrast: 14.9 ml of Gadavist was administered.

COMPARISON: Prostate MRI dated 4/3/2019.

FINDINGS:

Prostate size: 5.4 [CC] x 4.2 [AP] x 5.4 [transverse] cm for an overall volume of 64 cc.
Intra-vesical protrusion: None

Peripheral zone hemorrhage: None

Lesion localization:

LESION: 1
PI-RADS Assessment Category: 4, High (clinically significant cancer likely)
T2-weighted images: 3 (Heterogeneous or non-circumscribed round moderate hypointensity)
Diffusion-weighted images: 4 (focal marked decreased ADC & marked increased high b-value signal; <1.5 cm)
Dynamic post-contrast images: (+) focal AND earlier than or contemporaneously with enhancement of adjacent normal prostat tissue AND corresponds to suspicious finding on T2WI and/or DWI
Size: 19 x 11 mm as measured on image 8 of series 13 (Dynamic post-contrast image)
Side: Left
Location within transverse plane: Posteromedial
Level of prostate: Apex
Zone: Peripheral
Extra-prostatic extension: Overlying capsular irregularity without gross EPE

Additional peripheral zone findings: None
Additional transition zone findings: Enlarged and heterogeneous in appearance, consistent with BPH.

Extraprostatic extension: See above.

Seminal vesicle invasion: No evidence of seminal vesicle invasion.

Lymph nodes: No pathologic pelvic lymph nodes.

Osseous structures: No aggressive osseous lesion.

Additional findings: Fat-containing right inguinal hernia.

Electronic Signature: I personally reviewed the images and agree with this report. Final Report: Dictated by Fellow Soumya Vig and Signed by Attending Andrew Rosenkrantz MD 6/11/2020 3:08 PM

IMPRESSION:

19 x 11 mm left posteromedial apex peripheral zone lesion. PI-RADS 4, high (clinically significant cancer likely). Overlying capsu irregularity without gross EPE

Performing Organization	Address	City/State/Zipcode	Phone Number
NYU RADIOLOGY SWF			

PSA FREE (PSA, TOTAL AND % FREE) - Final result (05/04/2020 11:12 AM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
PSA TOTAL	6.6 Comment: (NOTE) INTERPRETIVE INFORMATION: Prostate Specific Antigen The Roche PSA electrochemiluminescent immunoassay was used. Results obtained with different test methods or kits cannot be used interchangeably. The Roche PSA method is approved for use as an aid in the detection of prostate cancer when used in conjunction with a digital rectal exam in men age 50 and older. The Roche PSA method is also indicated for the serial measurement of PSA to aid in the prognosis and management of prostate cancer patients. Elevated PSA concentrations can only suggest the presence of prostate cancer until biopsy is performed. PSA concentrations can also be elevated in benign prostatic hyperplasia or inflammatory conditions of the prostate. PSA is generally not elevated in healthy men or men with non- prostatic carcinoma.	0.0 - 4.0 ng/mL	NYU WINTHROP LAB	
PSA FREE	0.8	ng/mL	NYU WINTHROP LAB	
PSA % FREE	12 Comment: (NOTE) INTERPRETIVE INFORMATION: Prostate Specific Antigen, Free Percentage ARUP uses the Roche Free PSA electrochemiluminescent immunoassay method in conjunction with the Roche PSA	%	NYU WINTHROP LAB	

immunoassay method to determine the free PSA percentage. Values obtained with different assay methods should not be used interchangeably. The free PSA percentage is an aid in distinguishing prostate cancer from benign prostatic conditions in men age 50 and older with a total PSA between 3 and 10 ng/mL and negative digital rectal examination findings. Prostatic biopsy is required for the diagnosis of cancer.
In patients with total PSA concentrations of 4-10 ng/mL, the probability of finding prostate cancer on needle biopsy by age in years is:

%fPSA	50-59	60-69	70 or older
0 - 10%	49%	58%	65%
11 - 18%	27%	34%	41%
19 - 25%	18%	24%	30%
Greater than 25%	9%	12%	16%

Other factors may help determine the actual risk of prostate cancer in individual patients.
Performed by ARUP Laboratories, 500 Chipeta Way, SLC,UT 84108 800-522-2787 www.aruplab.com, Julio Delgado, MD, Lab. Director

Specimen

blood - Peripheral

Performing Organization	Address	City/State/Zipcode	Phone Number
NYU WINTHROP LAB			

MRI PROSTATE W&WO IVC (MRI PROSTATE WITH AND WITHOUT IV CONTRAST) - Final result (04/03/2019 11:43 EDT)

Specimen

Impressions	Performed At
IMPRESSION:	NYU RADIOLOGY SW

21 x 8 mm left posteromedial apex peripheral zone lesion. PI-RADS 3, intermediate (clinically significant cancer equivocal). Lesion is more conspicuous since prior MRI, possibly due to differences in technique.

more inferior lesion is likely along the superior margin of Lesion 1 described above.

No extraprostatic extension, seminal vesicle invasion, or pelvic lymphadenopathy.

Diffuse decreased T2 signal and avid enhancement of the peripheral zone bilaterally, possibly inflammatory.

Narrative	Performed At
MRI Prostate with and without intravenous contrast	NYU RADIOLOGY SWF

INDICATION: Gleason 3+3 prostate cancer diagnosed in April 2018 (right lateral apex-midgland), on active surveillance. Most recent PSA 6.3 ng/mL (January 2019). Upcoming fusion prostate biopsy planned for 4/8/2019.

TECHNIQUE: Multi-parametric 3.0 Tesla pelvic phased-array coil MRI was performed, including multiplanar T2-weighted images, diffusion-weighted images (including high b-1500 images and ADC map), and dynamic contrast-enhanced images of the prostate. In-and-opposed-phase T1-weighted images and pre- and post-contrast T1-weighted images of the entire pelvis were also obtained.

CONTRAST: 13.43 cc Gadavist.

COMPARISON: MRI prostate 1/19/2019.

FINDINGS:

Prostate size: 5.2 [CC] x 3.8 [AP] x 5.1 [transverse] cm for an overall volume of 52.4 cc.
Intra-vesical protrusion: None

Peripheral zone hemorrhage: None

Lesion localization:

The previously described lesions from prostate MRI of 1/19/2019 are no longer appreciated, and likely represent resolved foci of inflammation.

LESION: 1 (more conspicuous since prior MRI, possibly due to differences in technique)
PI-RADS Assessment Category: 3, Intermediate (presence of clinically significant cancer equivocal
T2-weighted images: 3 (Heterogeneous or non-circumscribed round moderate hypointensity)
Diffusion-weighted images: 3 (focal [discrete and different from background] hypointense on ADC and/or focal hyperintense on high b-value DWI; may be markedly hypointense on ADC or markedly hyperintense on high b-value DWI, but not both)
Dynamic post-contrast images: (-) no early or contemporaneous enhancement OR diffuse multifocal enhancement not corresponding to a focal finding on T2WI and/or DWI OR focal enhancement corresponding to a lesion demonstrating features of BPH on T2WI (including features of extruded BPH in the PZ)
Size: 21 x 8 mm as measured on image 11 of series 8 (ADC map)
Side: Left
Location within transverse plane: Posteromedial
Level of prostate: Apex
Zone: Peripheral zone
Extra-prostatic extension: Broadly abuts capsule without visualized gross EPE

Previously noted small left peripheral zone lesions are not well seen, although the more inferior lesion is likely along the superior margin of Lesion 1 described above.

Additional peripheral zone findings: Diffuse decreased T2 signal and avid enhancement bilaterally, possibly inflammatory.
Additional transition zone findings: Enlarged and heterogeneous in appearance, consistent with BPH.

Extraprostatic extension: See above.

Seminal vesicle invasion: No evidence of seminal vesicle invasion.

Lymph nodes: No pathologic pelvic lymph nodes.

Osseous structures: No aggressive osseous lesion.

Additional findings: Large right and small left fat-containing inguinal hernias.

Electronic Signature: I personally reviewed the images and agree with this report.
Final Report: Dictated by Fellow Michael King and Signed by Attending Justin Ream MD 4/3/2019 12:37 PM

Interface, Rad In - 04/03/2019 12:39 PM EDT
MRI Prostate with and without intravenous contrast

INDICATION: Gleason 3+3 prostate cancer diagnosed in April 2018 (right lateral apex-midgland), on active surveillance. Most r
PSA 6.3 ng/mL (January 2019). Upcoming fusion prostate biopsy planned for 4/8/2019.

TECHNIQUE: Multi-parametric 3.0 Tesla pelvic phased-array coil MRI was performed, including multiplanar T2-weighted images
diffusion-weighted images (including high b-1500 images and ADC map), and dynamic contrast-enhanced images of the prosta
In-and-opposed-phase T1-weighted images and pre- and post-contrast T1-weighted images of the entire pelvis were also
obtained.

CONTRAST: 13.43 cc Gadavist.

COMPARISON: MRI prostate 1/19/2019.

FINDINGS:

Prostate size: 5.2 [CC] x 3.8 [AP] x 5.1 [transverse] cm for an overall volume of 52.4 cc.
Intra-vesical protrusion: None

Peripheral zone hemorrhage: None

Lesion localization:

The previously described lesions from prostate MRI of 1/19/2019 are no longer appreciated, and likely represent resolved foci
inflammation.

LESION: 1 (more conspicuous since prior MRI, possibly due to differences in technique)
PI-RADS Assessment Category: 3, Intermediate (presence of clinically significant cancer equivocal
T2-weighted images: 3 (Heterogeneous or non-circumscribed round moderate hypointensity)
Diffusion-weighted images: 3 (focal [discrete and different from background] hypointense on ADC and/or focal hyperintense or
high b-value DWI; may be markedly hypointense on ADC or markedly hyperintense on high b-value DWI, but not both)
Dynamic post-contrast images: (-) no early or contemporaneous enhancement OR diffuse multifocal enhancement not
corresponding to a focal finding on T2WI and/or DWI OR focal enhancement corresponding to a lesion demonstrating features
BPH on T2WI (including features of extruded BPH in the PZ)
Size: 21 x 8 mm as measured on image 11 of series 8 (ADC map)
Side: Left
Location within transverse plane: Posteromedial
Level of prostate: Apex
Zone: Peripheral zone
Extra-prostatic extension: Broadly abuts capsule without visualized gross EPE

Previously noted small left peripheral zone lesions are not well seen, although the more inferior lesion is likely along the superi
margin of Lesion 1 described above.

Additional peripheral zone findings: Diffuse decreased T2 signal and avid enhancement bilaterally, possibly inflammatory.
Additional transition zone findings: Enlarged and heterogeneous in appearance, consistent with BPH.

Extraprostatic extension: See above.

Seminal vesicle invasion: No evidence of seminal vesicle invasion.

Lymph nodes: No pathologic pelvic lymph nodes.

Osseous structures: No aggressive osseous lesion.

Additional findings: Large right and small left fat-containing inguinal hernias.

Electronic Signature: I personally reviewed the images and agree with this report. Final Report: Dictated by Fellow Michael King
Signed by Attending Justin Ream MD 4/3/2019 12:37 PM

IMPRESSION:

21 x 8 mm left posteromedial apex peripheral zone lesion. PI-RADS 3, intermediate (clinically significant cancer equivocal). Lesio

Previously noted small left peripheral zone lesions are not well seen, although the more inferior lesion is likely along the superio margin of Lesion 1 described above.

No extraprostatic extension, seminal vesicle invasion, or pelvic lymphadenopathy.

Diffuse decreased T2 signal and avid enhancement of the peripheral zone bilaterally, possibly inflammatory.

Performing Organization	Address	City/State/Zipcode	Phone Number
NYU RADIOLOGY SWF			

URINALYSIS WITH REFLEX TO MICROSCOPY - Final result (01/28/2019 11:59 AM EST)

Component	Value	Ref Range	Performed At	Pathologist Signature
COLOR	AMBER		NYU WINTHROP LAB	
PROTEIN, URINE	NEG		NYU WINTHROP LAB	
OCCULT BLOOD, URINE	NEG		NYU WINTHROP LAB	
Urine Glucose Lab	NEG		NYU WINTHROP LAB	
KETONES, URINE	TRACE		NYU WINTHROP LAB	
PH, URINE	5.0		NYU WINTHROP LAB	
SPECIFIC GRAVITY, URINE	1.032	RI	NYU WINTHROP LAB	
BILE SALTS URINE	NEG		NYU WINTHROP LAB	
URINE NITRITE	NEG		NYU WINTHROP LAB	
URINE LEUK ESTERASE	NEG		NYU WINTHROP LAB	
CLARITY, URINE	CLEAR Comment: Performed at NYU Winthrop Hospital, Mineola, NY 11501		NYU WINTHROP LAB	

Specimen
Urine - Urine, voided

Performing Organization	Address	City/State/Zipcode	Phone Number
NYU WINTHROP LAB			

URINE CULTURE, ROUTINE - Final result (01/28/2019 11:59 AM EST)

Component	Value	Ref Range	Performed At	Pathologist Signature
SPECIMEN DESCRIPTION	URINE		NYU WINTHROP LAB	
Special Request	NONE		NYU WINTHROP LAB	
CULTURE/RESULT	<1000 COL/ML		NYU WINTHROP LAB	
CULTURE/RESULT	Performed at NYU Winthrop Hospital, Mineola, NY 11501		NYU WINTHROP LAB	
REPORT STATUS	02052019 FINAL		NYU WINTHROP LAB	

Performing Organization	Address	City/State/Zipcode	Phone Number
NYU WINTHROP LAB			

MRI PROSTATE W&WO IVC (MRI PROSTATE WITH AND WITHOUT IV CONTRAST) - Final result (01/19/2019 2:13 PM EST)

Specimen

Impressions	Performed At
IMPRESSION: 2 lesions in the left peripheral zone as above compatible with PI-RADS Assessment Category: 3 lesions. Organ confined disease	NYU RADIOLOGY SWP

Narrative	Performed At
MRI Prostate with and without intravenous contrast INDICATION: Prostate biopsy on May 2018. PSA: 6.7 from September 2018, outside MRI from April 2018 demonstrated PI-RADS 4 lesion in the left peripheral zone. TECHNIQUE: Multi-parametric 3.0 Tesla pelvic phased-array coil MRI was performed, including multiplanar T2-weighted images, diffusion-weighted images (including ultra high b-1500 images and ADC map), and dynamic contrast-enhanced images of the prostate. In-and-opposed-phase T1-weighted images and pre- and post-contrast T1-weighted images of the entire pelvis were also obtained. CONTRAST: 20 mL dotarem COMPARISON: Outside MR from April 2018 not available for comparison. FINDINGS: Prostate size: 5.8 [CC] x 5.1 [AP] x 5.7 [transverse] cm for an overall volume of 88 cc. Peripheral zone hemorrhage: None LESION: 1 PI-RADS Assessment Category: 3 T2-weighted images: Peripheral zone is diffusely heterogeneous without evidence of a well-circumscribed focal lesion. Diffusion-weighted images: There is a 5 mm focus of low ADC signal in the left aspect of the peripheral zone (image 146 of series 502). This area is isointense on diffusion-weighted images. Dynamic post-contrast images: No enhancement Size: 5 x 4 mm as measured on image 164 of series 502 Side: Left Level of prostate: Midgland Zone: Peripheral Extra-prostatic extension: None LESION: 2 PI-RADS Assessment Category: 3 T2-weighted images: No focal lesion Diffusion-weighted images: 9 x 6 mm focus of low ADC signal in the left peripheral zone (image 244 of series 502). Isointense signal on high B value value diffusion-weighted images. Side: Left Level of prostate: Base Zone: Peripheral Extra-prostatic extension: None Additional peripheral zone findings: None Additional transition zone findings: Enlarged and heterogeneous in appearance, consistent with BPH. Extraprostatic extension: None	NYU RADIOLOGY SWP

Lymph nodes: No pathologic pelvic lymph nodes.

Osseous structures: No aggressive osseous lesion.

Additional findings: There is a right-sided fat-containing inguinal hernia..

Electronic Signature: I personally reviewed the images and agree with this report.
Final Report: Dictated by Resident Travis French MD and Signed by Attending Galina Levin MD 1/21/2019 6:51 PM

Procedure Note

Interface, Rad In - 01/21/2019 6:53 PM EST

MRI Prostate with and without intravenous contrast

INDICATION: Prostate biopsy on May 2018. PSA: 6.7 from September 2018, outside MRI from April 2018 demonstrated PI-RADS lesion in the left peripheral zone.

TECHNIQUE: Multi-parametric 3.0 Tesla pelvic phased-array coil MRI was performed, including multiplanar T2-weighted images diffusion-weighted images (including ultra high b-1500 images and ADC map), and dynamic contrast-enhanced images of the prostate. In-and-opposed-phase T1-weighted images and pre- and post-contrast T1-weighted images of the entire pelvis were obtained.

CONTRAST: 20 mL dotarem

COMPARISON: Outside MR from April 2018 not available for comparison.

FINDINGS:

Prostate size: 5.8 [CC] x 5.1 [AP] x 5.7 [transverse] cm for an overall volume of 88 cc.

Peripheral zone hemorrhage: None

LESION: 1
PI-RADS Assessment Category: 3
T2-weighted images: Peripheral zone is diffusely heterogeneous without evidence of a well-circumscribed focal lesion.
Diffusion-weighted images: There is a 5 mm focus of low ADC signal in the left aspect of the peripheral zone (image 146 of s
502). This area is isointense on diffusion-weighted images.
Dynamic post-contrast images: No enhancement
Size: 5 x 4 mm as measured on image 164 of series 502
Side: Left
Level of prostate: Midgland
Zone: Peripheral
Extra-prostatic extension: None

LESION: 2
PI-RADS Assessment Category: 3
T2-weighted images: No focal lesion
Diffusion-weighted images: 9 x 6 mm focus of low ADC signal in the left peripheral zone (image 244 of series 502). Isointen
on high B value value diffusion-weighted images.
Side: Left
Level of prostate: Base
Zone: Peripheral
Extra-prostatic extension: None

Additional peripheral zone findings: None
Additional transition zone findings: Enlarged and heterogeneous in appearance, consistent with BPH.

Extraprostatic extension: None

Seminal vesicle invasion: No evidence of seminal vesicle invasion.

Lymph nodes: No pathologic pelvic lymph nodes.

Osseous structures: No aggressive osseous lesion.

Additional findings: There is a right-sided fat-containing inguinal hernia..

Electronic Signature: I personally reviewed the images and agree with this report. Final Report: Dictated by Resident Travis Frenc MD and Signed by Attending Galina Levin MD 1/21/2019 6:51 PM

IMPRESSION:

2 lesions in the left peripheral zone as above compatible with PI-RADS Assessment Category: 3 lesions.

Organ confined disease

Performing Organization	Address	City/State/Zipcode	Phone Number
NYU RADIOLOGY SWF			

URINALYSIS WITH REFLEX TO MICROSCOPY - Final result (01/07/2019 10:46 AM EST)

Component	Value	Ref Range	Performed At	Pathologist Signatu
COLOR	YELLOW		NYU WINTHROP LAB	
PROTEIN, URINE	NEG		NYU WINTHROP LAB	
OCCULT BLOOD, URINE	NEG		NYU WINTHROP LAB	
Urine Glucose Lab	NEG		NYU WINTHROP LAB	
KETONES, URINE	NEG		NYU WINTHROP LAB	
PH, URINE	6.0		NYU WINTHROP LAB	
SPECIFIC GRAVITY, URINE	1.012	RI	NYU WINTHROP LAB	
BILE SALTS URINE	NEG		NYU WINTHROP LAB	
URINE NITRITE	NEG		NYU WINTHROP LAB	
URINE LEUK ESTERASE	NEG		NYU WINTHROP LAB	
CLARITY, URINE	CLEAR Comment: Performed at NYU Winthrop Hospital, Mineola, NY 11501		NYU WINTHROP LAB	

Specimen
Urine - Urine, voided

Performing Organization	Address	City/State/Zipcode	Phone Number
NYU WINTHROP LAB			

URINE CULTURE, ROUTINE - Final result (01/07/2019 10:46 AM EST)

Component	Value	Ref Range	Performed At	Pathologist Sig
SPECIMEN DESCRIPTION	URINE URINE		NYU WINTHROP LAB	
Special Request	NONE		NYU WINTHROP LAB	
CULTURE/RESULT	<1000 COL/ML		NYU WINTHROP LAB	
CULTURE/RESULT	Performed at NYU Winthrop Hospital, Mineola, NY 11501		NYU WINTHROP LAB	
REPORT STATUS	01082019 FINAL		NYU WINTHROP	

Specimen

Urine - Urine, voided

Performing Organization	Address	City/State/Zipcode	Phone Number
NYU WINTHROP LAB			

PSA FREE (PSA, % FREE) - Edited Result - FINAL (01/07/2019 10:46 AM EST)

Component	Value	Ref Range	Performed At	Pathologist Signature
PSA TOTAL	6.3	0.0 - 4.0 ng/mL		

Comment:
(NOTE)
Roche ECLIA methodology.
According to the American
Urological Association, Serum
PSA should
decrease and remain at
undetectable levels after
radical
prostatectomy. The AUA defines
biochemical recurrence as an
initial
PSA value 0.2 ng/mL or greater
followed by a subsequent
confirmatory PSA value 0.2 ng/mL
or greater.
Values obtained with different
assay methods or kits cannot be
used
interchangeably. Results cannot
be interpreted as absolute
evidence
of the presence or absence of
malignant disease.

Comment
Comment:
(NOTE)
The percent free PSA is
performed on a reflex basis only
when the
total PSA is between 4.0 and
10.0 ng/mL.

Specimen

US PROSTATE - Final result (01/07/2019)

Narrative	Performed At
This result has an attachment that is not available.	

Performing Organization	Address	City/State/Zipcode	Phone Number
EXTERNAL LOCATION			

PSA FREE (PSA, TOTAL AND % FREE) - Final result (11/20/2018)

blood - Peripheral vein

Narrative	Performed At
This result has an attachment that is not available.	

Performing Organization	Address	City/State/Zipcode	Phone Number
EXTERNAL LOCATION			

MRI SPINE LUMBAR W/WO CONTRAST (MRI LUMBAR SPINE WITH AND WITHOUT IV CONTRAST) - Final result (05/16/2018)

Narrative	Performed At
This result has an attachment that is not available.	

Performing Organization	Address	City/State/Zipcode	Phone Number
EXTERNAL LOCATION			

MRI PELVIS W CONTRAST (MRI PELVIS WITH IV CONTRAST) - Final result (04/04/2018)

Narrative	Performed At
This result has an attachment that is not available.	

Performing Organization	Address	City/State/Zipcode	Phone Number
EXTERNAL LOCATION			

Patient Contacts

Contact Name	Contact Address	Communication	Relationship to Patient
Brian Mignola	Unknown	347-308-3989 (Mobile)	Friend, Emergency Contact

Document Information

Primary Care Provider

Robert Kelter MD (Aug. 25, 2020 - Present)
929-455-2700 (Work)
929-455-2770 (Fax)
6740 Fourth Avenue
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BROOKLYN, NY 11220
Medicine, Internal Medicine

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Jun. 24, 1957 - Sep. 01, 20

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New York, NY 10016

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Appendix C

United Sleep Diagnostics, Inc

50 Rose Place Garden City Park, NY 11040
Telephone: 866-711-1299 / Fax: 888-539-3001

General Information					
Name:	Gagliardo, Joseph	Neck:	21in	Location:	Bay Ridge
MR #:	GUA-34696-P	BMI:	42	Ref. Phys:	Richard Yan, M.D.
Sex:	male	Height:	75 in	Date of Study:	3/22/2018
Age:	60, 06/24/57	Weight:	337 lb	Technologist:	Akhmar Magrufor, RPSGT
		ESS:	16	Scorer:	Kim Blackburn, RPSGT

PROCEDURE: SPLIT NIGHT

CHIEF COMPLAINT: The patient is a 60-year-old male who presents with symptoms of excessive daytime sleepiness, snoring, tiredness, headaches, difficulty initiating and maintaining sleep, waking with fast heart rate, acid taste in mouth, leg movements, tingling, jerking, kicks, breathing problems, choking, gasping, coughing, shortness of breath, unusual behavior during sleep, irregular sleep/wake patterns, difficulty staying awake, sudden weakness, sleep walking, sleep talking, and sleep eating. The patient is 75 inches tall and weighs 337 pounds, giving a Body Mass Index (BMI) of 42. The medical history is significant for back pain and high cholesterol. Medications include Vytorin and Hydrocodone. A Split Night study was ordered to rule out the diagnosis of obstructive sleep apnea and determine an optimal treatment pressure.

IMPRESSION: Nocturnal Polysomnogram (NPSG) was performed using a Split Night Protocol. The total recording time (TRT) for the baseline portion of recording was 135 minutes. Sleep onset occurred within 12 minutes of initiating the recording. During baseline, the patient experienced 166 arousals, 166 of which were respiratory-related, resulting in a Sleep Efficiency of 80%. This value is below the normal range and indicates an increased percentage of wakefulness during the recording period. The sleep architecture is disturbed due to an increased amount of wakefulness, an increased amount of Stage N1, an absence of Slow Wave Sleep (Delta), and an absence of REM sleep. The patient had 63% of Stage N1, 37% of Stage N2, 0% of Stage N3, 0% of Stage REM sleep.

Total recording for the CPAP segment was 260 minutes. After initiation of treatment, sleep onset occurred within 117 minutes of initiating the recording. During treatment, the patient experienced 16 arousals, 10 of which were respiratory-related, resulting in a Sleep Efficiency of 53%. This value is below the normal range and indicates an increased percentage of wakefulness during the recording period. The sleep architecture is disturbed due to an increased amount of wakefulness, an absence of Slow Wave Sleep (Delta), and a decreased amount of REM. The patient had 9% of Stage N1, 83% of Stage N2, 0% of Stage N3, 8% of Stage REM sleep.

During Baseline, there were 0 obstructive apneas, 0 mixed apneas, 0 central apneas, and 136 hypopneas, resulting in an apnea/hypopnea index (AHI) of 75.6 events per hour of sleep, which is severe (>30 per hour). The obstructive index is 75.6. The central index is 0.0. The positional AHI is as follows: Supine (75.58), Prone (0.00), Side (75.43). The REM AHI was 0. The NREM AHI was 76. The longest event was a 40 second Hypopnea with a minimum SaO2 of 91%. Most, if not all, respiratory events terminated in an arousal. The baseline SaO2 was 98%. The mean saturation across the entire recording period was 95%. The lowest desaturation was 88%. The patient spent of 1% total sleep time with a SaO2 below 90%. The patient spent of 0% total sleep time with a SaO2 below 88%. Snoring was noted during the recording. Respiratory effort related arousals (RERA's) is evident, resulting in a RERA index of 17.2 events per hour of sleep, 31 were scored in NREM sleep. The Respiratory Disturbance Index (RDI) was 92.8.

During the Treatment segment, there were 0 obstructive apneas, 0 mixed apneas, 0 central apneas, and 11 hypopneas, resulting in an apnea/hypopnea index (AHI) of 4.8 events per hour of sleep, which is normal (0-5 per hour). The obstructive index is 4.8. The central index is 0.0. The REM AHI was 5.7. The NREM AHI was 4.7. The longest event was a 66 second Hypopnea with a minimum SaO2 of 92%. Most, if not all, respiratory events terminated in an arousal. The baseline SaO2 was 96%. The mean saturation across the entire recording period was 94%. The lowest desaturation was

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Gerard Lombardo, M.D. on 2018/03/26 21:09:45.

89%. The patient spent of 0% total sleep time with a SaO2 below 90%. The patient spent of 0% total sleep time with a SaO2 below 88%. Respiratory effort related arousals (RERA's) is evident, resulting in a RERA index of 2.2 events per hour of sleep, 4 were scored in NREM sleep and 1 was scored in REM sleep. The Respiratory Disturbance Index (RDI) was 7.0.

There were 0 periodic limb movements during sleep (PLMS).

The EKG revealed no cardiac arrhythmias.

Per physician order and because of the severe obstructive sleep apnea, continuous positive airway pressure was started at 6 cm H2O and increased up to a pressure of 14 cm H2O. CPAP of 14 cm H2O appeared to be the most optimal pressure during this study. This pressure appeared to relieve most obstructive sleep apnea allowing for the SaO2 to remain above 90% in NREM sleep. Lower levels of positive airway pressure were associated with continued obstructive sleep apnea. A chin strap was added at 4:09 am.

IMPRESSION:

Severe obstructive sleep apnea with an optimal response to CPAP.

RECOMMENDATIONS:

1) Begin on continuous positive airway pressure at 14 cm H2O via a ResMed AirFit P10 nasal pillows mask, size medium with a chin strap.
2) Review of good sleep hygiene measures. Weight control advised.
3) Review safety issues relative to daytime sleepiness and substances to avoid prior to sleep.
4) Compliance data review and follow up in 2-4 weeks.
5) Avoid activities requiring sustained vigilance if sleepy.
6) The patient should be advised to discuss this diagnosis with all health care providers including those planning to perform procedures involving anesthesia or any form of sedation .

I certify that I have reviewed the entire raw data recording as part of the preparation for the generation of this report in accordance with the Standards of Accreditation of the American Academy of Sleep Medicine (AASM).

Thank you.
Sincerely,

Gerard T Lombardo MD, FCCP
Certified sleep medicine, ABIM

Study scored using AASM rule 1B.

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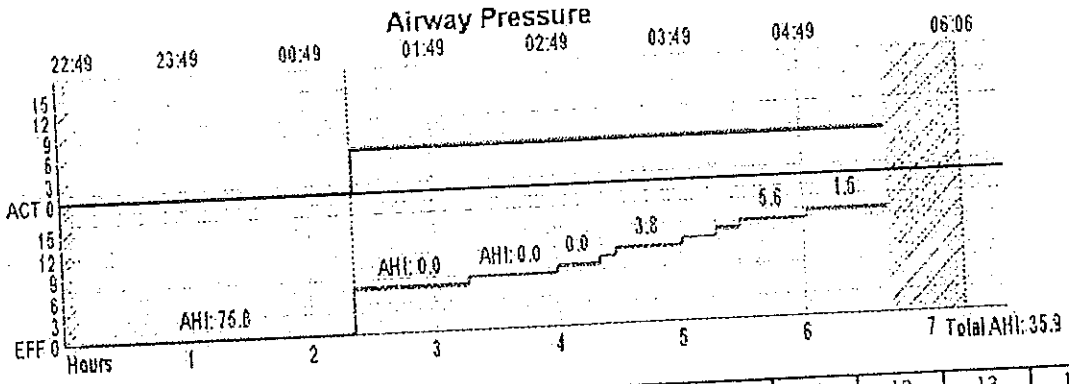
Gerard Lombardo, M.D. on 2018/03/26 21:09:45.

Gagliardo, Joseph - DOB 06/24/1957 MR# GUA-34696-P - Acct# Scheduled and Conf...



Pressure	IPAP/EPAP	00	06	07	08	09	10	11	12	13	14
	O2 Vol	0	0	0	0	0	0	0	0	0	0
Time	TRT	135.0m	55.5m	43.0m	21.0m	8.0m	32.5m	16.5m	11.5m	32.5m	39.5m
	TST	108.0m	0.0m	0.0m	2.0m	8.0m	32.0m	14.5m	10.5m	32.0m	39.0m
Sleep Stage	% Wake	20.0	100.0	100.0	90.5	0.0	1.5	12.1	8.7	1.5	1.3
	% REM	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	32.8	0.0
	% N1	63.4	0.0	0.0	100.0	12.5	1.6	31.0	9.5	6.3	5.1
	% N2	36.6	0.0	0.0	0.0	87.5	98.4	69.0	90.5	60.9	94.9
	% N3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	% MT	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Respiratory	Total Events	136	0	0	0	1	2	3	1	3	1
	Obs. Apn.	0	0	0	0	0	0	0	0	0	0
	Mixed Apn.	0	0	0	0	0	0	0	0	0	0
	Cen. Apn.	0	0	0	0	0	0	0	0	0	0
	Hypopneas	136	0	0	0	1	2	3	1	3	1
	AHI	75.56	0.00	0.00	0.00	7.50	3.75	12.41	5.71	5.63	1.54
	Supine AHI	75.58	0.00	0.00	0.00	0.00	0.00	24.00	5.71	5.63	2.61
	Prone AHI	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Side AHI	75.43	0.00	0.00	0.00	7.50	3.75	6.32	0.00	0.00	0.00
Desat Profile	<= 90%	3.9m	0.0m	0.0m	0.0m	0.0m	0.0m	0.1m	0.0m	0.3m	0.0m
	<= 80%	0.0m	0.0m	0.0m	0.0m	0.0m	0.0m	0.0m	0.0m	0.0m	0.0m
	<= 70%	0.0m	0.0m	0.0m	0.0m	0.0m	0.0m	0.0m	0.0m	0.0m	0.0m
	<= 60%	0.0m	0.0m	0.0m	0.0m	0.0m	0.0m	0.0m	0.0m	0.0m	0.0m
Arousal Index	Apnea	0	0	0	0	0	0	0	0	0	0
	Hypopnea	75	0	0	0	0	2	8	6	0	2
	LM	0	0	0	0	0	0	0	0	0	0
	Spontaneous	0	0	0	0	0	0	0	0	2	8

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Age:	60, 06/24/57	Weight:	337 lb	Technologist:	Akhmar Magrufor, RPSGT
		ESS:	16	Scorer:	Kim Blackburn, RPSGT

Medications
Vytorin, Hydrocodone
Medical History
back pain, high cholesterol
Clinical Indication
snoring, EDS/fatigue, witnessed apnea, choking/gasping during sleep, coughing, problems falling/staying asleep, leg movements
Technologist Comments

SPLIT NIGHT STUDY

Baseline Phase

Start of Study: 10:55:17 PM

End of Baseline: 01:10:24 AM

Patient Data:	TIME(min)	%
Total Recording Time (TRT/TIB):	135.0 min/451.6 min	
Total Sleep Time (TST)	108.0 min/407.3 min	
Sleep Efficiency:	80.0%/90.0%	
Awake Time:	27.0 min	
Stage N1:	68.5 min	63.4%/9.7%
Stage N2:	39.5 min	36.6%/56.8
Stage N3:	0.0 min	0.0%/2.7%
Stage REM:	0.0 min	0.0%/23.1%
Stage N1 Latency:	12.5 min	
Stage N2 Latency:	17.0 min	
Sleep Onset:	12.5 min/8.3 min	
REM Latency:	0.0 min/83.9 min	
REM PERIODS:	0/5	
Supine Sleep:	90.5 min	83.8%

EKG DATA	Avg	Max	Min
Awake:	69	88	57
Asleep:	62	74	53

EKG Events Noted: no cardiac arrhythmias

PLMS & AROUSAL DATA	Total Events	Total w/arousals	Index w/arousals
Total LMs during PLMS	0	0	0
Isolated Leg Movements	0	0	0
Spontaneous		0	0
Total	0	0	0

SaO2 DATA	
Baseline SaO2:	98%
Average SaO2:	95%
Total	

Left Side Sleep:	17.5 min	16.2%
Right Side Sleep:	0.0 min	0.0%
Prone Sleep:	0.0 min	0.0%

Desat's<90%:	11

The longest event was a 40 seconds obstructive Hypopnea with a minimum SaO2 of 91%.

The lowest SaO2 was 88% associated with a 31 seconds obstructive Hypopnea.

Gagliardo, Joseph

(S) = Supine, (L) = Left Side, (R) = Right Side, (P) = Prone

RESPIRATORY DATA	TOTAL & INDEX	REM	NREM	S	L	R	P
Obstr. Apnea	0 0.0	0	0	0	0	0	0
Central Apnea	0 0.0	0	0	0	0	0	0
Mixed Apnea	0 0.0	0	0	0	0	0	0
Hypopnea	136 75.6	0	136	114	22	0	0
Total Events	**136**	**0**	**136**	**114**	**22**	**0**	**0**
AHI	75.6	0.0					

RERA's *(Respiratory Effort Related Arousals)*	TOTAL	REM	NREM
RERA Count	31	0	31
RERA Index	17.2		

Gagliardo, Joseph

CPAP Titration Phase

CPAP start time: 01:10:24 AM		CPAP end time: 05:30:33 AM	

Patient Data:	TIME(min)	%
Total Recording Time (TRT/TIB):	260.0 min/451.6 min	
Total Sleep Time (TST)	138.0 min/407.3 min	
Sleep Efficiency:	53/90%	
Awake Time:	122.0 min	
Stage N1:	13.0 min	9%/10%
Stage N2:	114.5 min	83%/57%
Stage N3 :	0.0 min	0%/3%
Stage REM:	10.5 min	8%/23%
Stage N1 Latency:	117.5 min	
Stage N2 Latency:	120.5 min	
Sleep Onset:	117.5 min/8.3 min	
REM Latency:	85.0 min/83.9 min	
REM PERIODS:	1/5	
Supine Sleep:	70.5 min	51.1%
Left Side Sleep:	67.5 min	48.9%
Right Side Sleep:	0.0 min	0.0%
Prone Sleep:	0.0 min	0.0%

EKG DATA	Avg	Max	Min
Awake:	64	85	56
Asleep:	60	82	50

EKG Events Noted: no cardiac arrhythmias

PLMS & AROUSAL DATA	Total Events	Total w/arousals	Index w/arousals
Total LMs during PLMS	0	0	0
Isolated Leg Movements	0	0	0
Spontaneous		6	3
Total	0	6	3

SaO2 DATA	
Baseline SaO2:	96%
Average SaO2:	94%
Total Desat's<90%:	1

The longest event was a 66 seconds obstructive Hypopnea with a minimum SaO2 of 92%.

The lowest SaO2 was 89% associated with a 46 seconds obstructive Hypopnea.

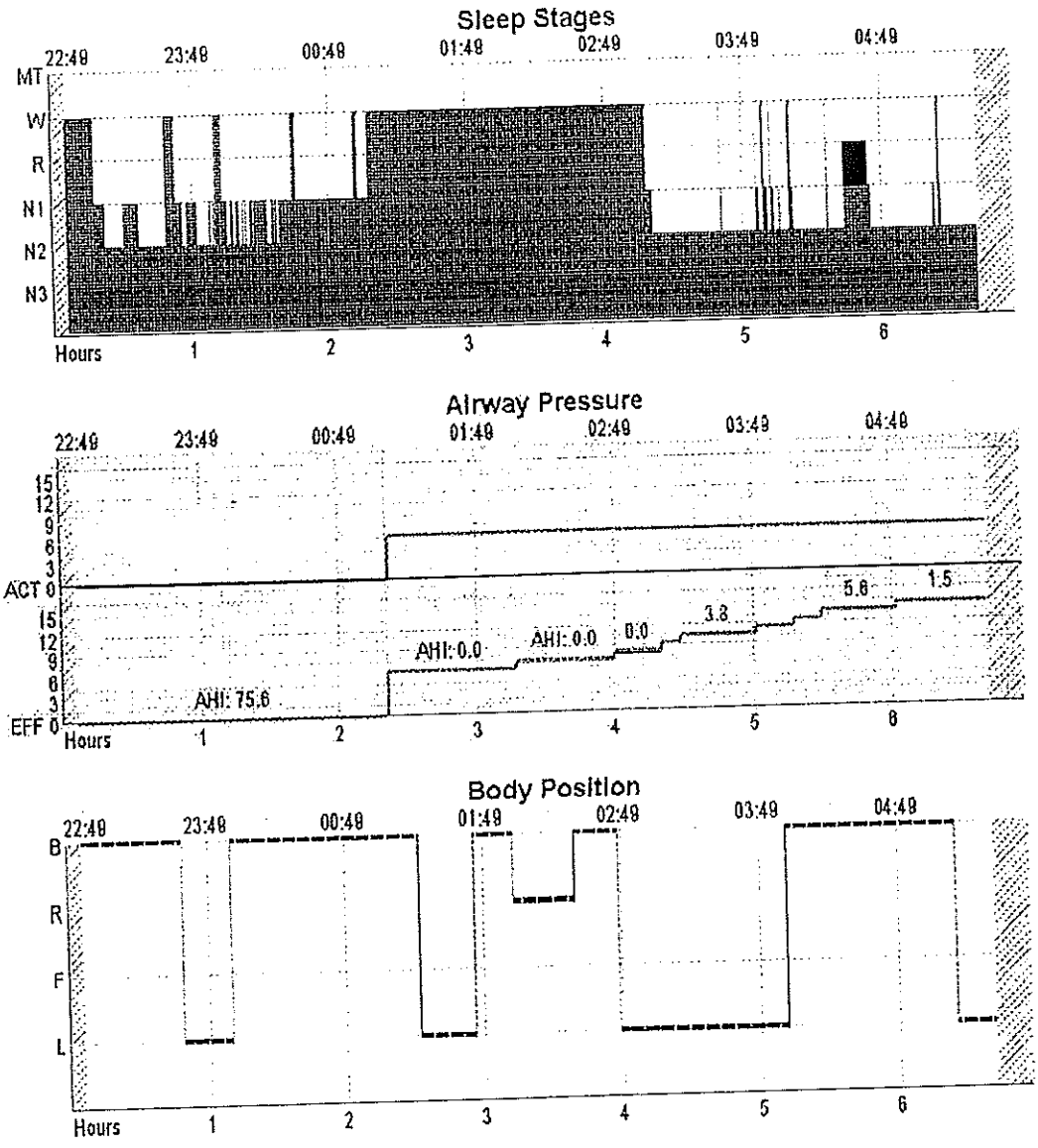
Gagliardo, Joseph

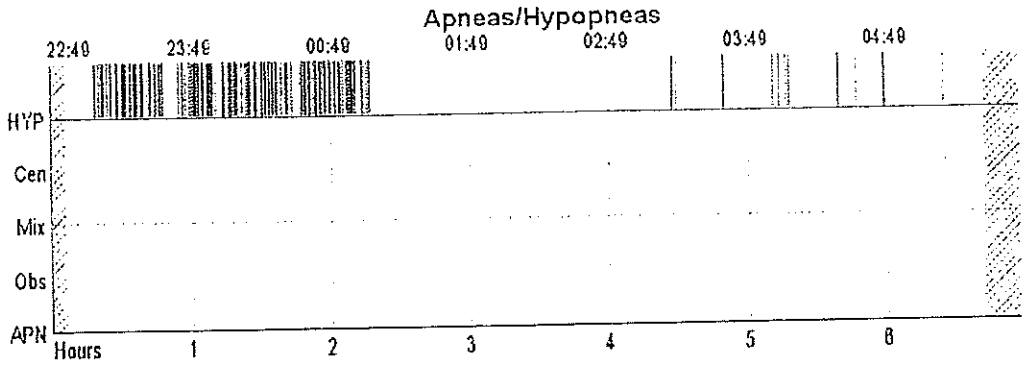
(S) = Supine, (L) = Left Side, (R) = Right Side, (P) = Prone

RESPIRATORY DATA	TOTAL & INDEX	REM	NREM	S	L	R	P
Obstr. Apnea	0 0.0	0	0	0	0	0	0
Central Apnea	0 0.0	0	0	0	0	0	0
Mixed Apnea	0 0.0	0	0	0	0	0	0
Hypopnea	11 4.8	1	10	7	4	0	0
Total Events	11	1	10	7	4	0	0
AHI	4.8	5.7					

RERA's *(Respiratory Effort Related Arousals)*	TOTAL	REM	NREM
RERA Count	5	1	4
RERA Index	2.2		

Gagliardo, Joseph




Apneas/Hypopneas
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23:49
00:49
01:49
02:49
03:49
04:49
HYP
Cen
Mix
Obs
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Hours
1
2
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4
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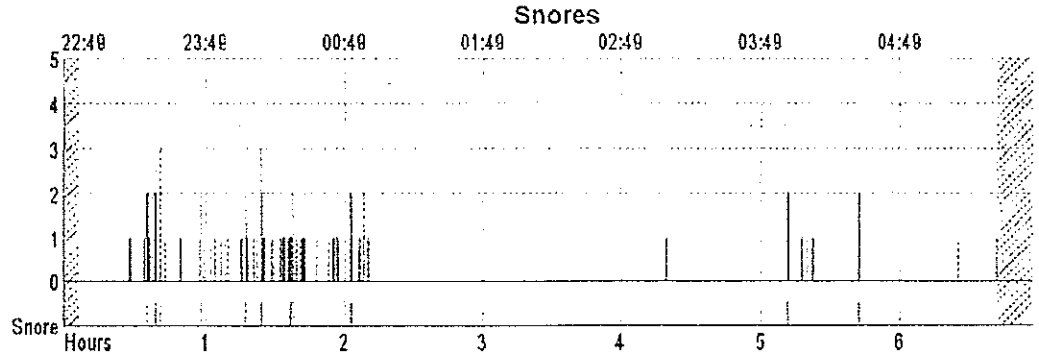
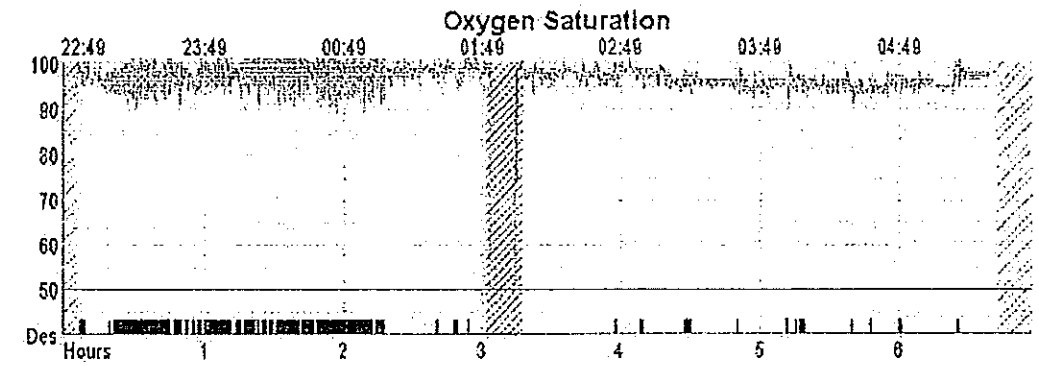
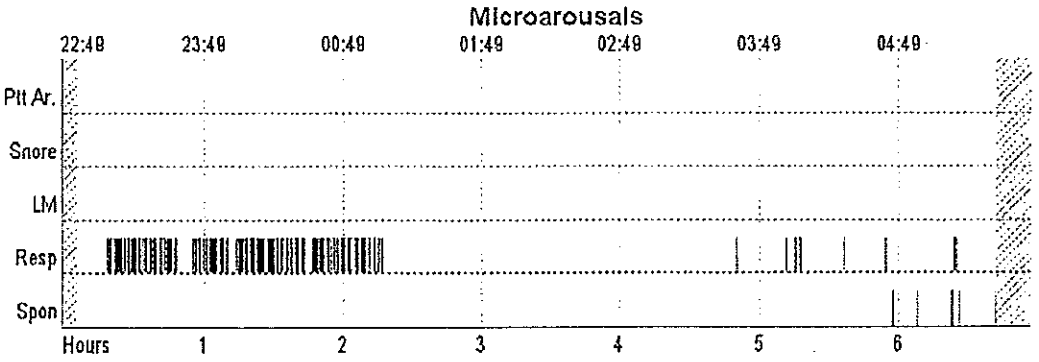
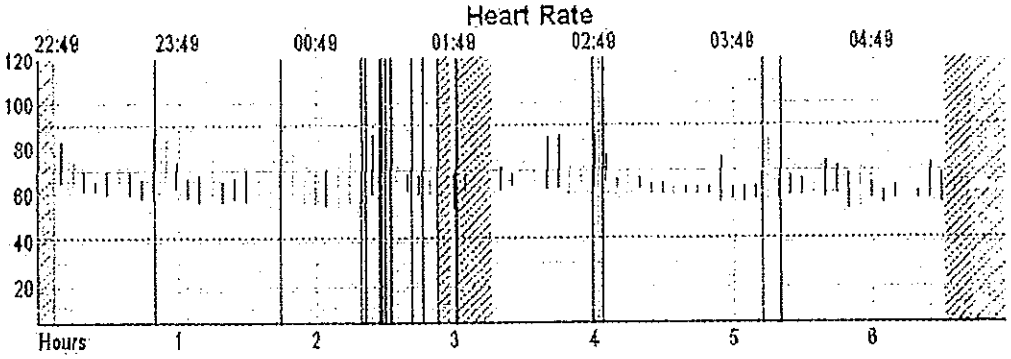
6

Gagliardo, Joseph








Heart Rate
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01:49
02:49
03:49
04:49
120
100
80
60
40
20
Hours
1
2
3
4
5
6

Appendix D

Barry D. Holzer, M.D.
Child, Adolescent, & Adult Psychiatry

137-18 Jewel Avenue
Kew Gardens Hills, NY 11367
Phone (718) 544-7912

2350 Ocean Ave – suite 2J
Brooklyn, NY 11229
Phone (718) 743-7600

103 Wood Lane South
Woodmere, NY 11598
Fax (718) 743-7630

Psychiatric Note

Re; Joseph Galiardo
DOB: 6/24/1957

To Whom It May Concern:

Joseph Gagliardo has a diagnosis of AD/HD.
His current medication includes:
Adderall (dextroamphetamine-amphetamine mixed salts) 10 mg QAM

Please make sure he continues to receive his medication daily.

Sincerely,

Barry Holzer, M.D.
Child, Adolescent and Adult Psychiatrist

Joseph Guagliardo #87290-054
FCI P.O. Box 2000
Joint Base MDL, NJ 08640

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